AN ENQUIRY INTO PROVISION OF ABORTION SERVICES IN MADHYA PRADESH

MARCH 2004

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Manasa, Bangalore

Research Study Supported by CEHAT Mumbai
For Limited Circulation Only

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AN ENQUIRY INTO PROVISION OF ABORTION SERVICES IN MADHYA PRADESH

Rationale

Though the MTP Act 1971 has legalised abortions with the consent of only the woman, the necessary facilities for conducting abortions are not adequately available in the public or the private sector. While in the public sector several facilities, which are supposed to provide the service, are not providing it, the availability of providers with the necessary training and institutions with the required registration under the Act is very limited. The training facilities for imparting training in MTP are also limited in number. This has given rise to a lack adequate facilities and providers for conducting safe abortions and to the mushrooming of unregistered facilities and untrained providers who conduct abortions, causing concerns of quality and safety. In addition to unregistered providers with formal qualification in one or other stream of medicine who are conducting abortions, the informal providers who do not have any formal qualifications are also conducting abortions. The study intends to look into the provision of abortion services in detail and to come up with findings which would facilitate making necessary changes in the registration, training, quality of abortion service and to improve the provision of the service in such a way that it benefits the end user: the woman seeking abortion. With this end, the study has the following objectives, which are listed below, as a sub section.

The state of MP was selected for the study based on an analysis of the women's health and related indicators of states of India and MP's score in it. The indicators selected for this ranking included institutional deliveries, maternal mortality ratio, neonatal mortality rate, female infant mortality rate, couple protection rate, total fertility rate and female literacy rate. The indicators of the pre-divided state of MP before the passage of the Chattisgarh formation Bill was taken into consideration. The scores of different states were aggregated under four clusters. The combined state of MP was ranked along with UP and Rajasthan as Fourth category state i.e. in the lowest category.

Objectives

The study intends to understand and analyse issues related to the provision of abortion services in public and private sectors with the following objectives:

- ✓ Management of abortion services including management of complications.
- ✓ Technologies used.
- ✓ Registration, training and certification.
- ✓ Availability, technical competence, training needs and current training facilities/ programmes for abortion care providers.
- ✓ Utilisation of facilities.
- ✓ Adequacy/ appropriateness of the MTP Act from the providers perspective.
- ✓ Costing and Finance related issues

Sampling: Selection of Districts

The *values of six variables- sex ratio, percentage of institutional deliveries, female IMR, female literacy, total fertility rate (TFR) and couple protection rate (CPR) were ranked for each district.* The ranks were added up to arrive at a composite score for each district, and the district with the lowest rank scored the rank one and so on. From the ranked districts, one district each from the top and the bottom quartiles were selected, excluding the top and the bottom ranked districts as outliers. District of Ujjain as second most developed and district of Sidhi as second least developed were selected from the highest and the lowest quartiles. Some new districts and blocks were created in M P in the last few years and hence the selection of districts were restricted to the old districts.

Selection of Blocks

The blocks were first ranked according to their percentage of urban population, which was taken as an indicator of development. The ranked blocks were then divided into three groups, one group that was closest to the average urbanisation percentage of the district, another group, which had blocks above the district urbanisation percentage and the third group below the average level of urbanisation. In the district of Ujjain with an urbanisation percentage of 38.74, Ujjain block with 76.40% urbanisation, was selected as the block with above average urbanisation, Kachrod block with 39.35% urbanisation as the block with average urbanisation and the Tarana block with 9.87% urbanisation was selected as the block with below average urbanisation. Similarly in the district of Sidhi with an urbanisation percentage of 14.28, Baidhan with 44.32% was selected as the above average block, Gopanbandhas block with 19.72% as the block closest to average urbanisation and Rampur Naikin with 8.57% urbanisation was selected as the below average block.

Sample Size, Sample Selection and Mapping

In each selected block all the formal public providers/institutions like Primary Health Centres (PHC), Community Health Centres (CHCs), civil hospitals, District hospitals and hospitals of Public Sector Undertakings and private formal providers; both registered and unregistered were mapped using a listing form. The listing form recorded a few basic characteristics of the facility and the willingness to participate in the study. For the purpose of this study formal providers are defined as one who has been trained in a formal institution, which awards a degree or diploma like MBBS, BAMS, BUMS, BHMS, etc, and conduct abortions. Informal Providers are defined as those persons, who do not have recognised qualifications in any of the above mentioned streams, but conduct abortions.

For listing the providers, help from the CMOs of both districts, superintendents of district hospitals, nurses, medical representatives, chemists, hospitals, local journalists, and other concerned people were utilised. A detailed map of each district and of selected blocks, which were collected from the concerned Block Development Officers, were also utilised for the purpose.

Out of the 33 identified public facilities, which were supposed to provide abortion service only 11 were providing the service. They participated with the study and have got included in the sample.

Out of the 68 identified private formal facilities in both the districts together, only 51 co –operated with the study, and got included in the sample. Non participation of private providers was the highest in Ujjain District, which had a concentration of organised providers in the city who refrained to participate. Of the 42 private providers in Ujjain only 25 participated in the study. In Sidhi district, the total number of private formal providers was small. Since they were probably less organised also, all the 26 formal private providers/institutions participated.

Number of Mapped Facilities and Those who Agreed to Participate by Facility Type and District

State	Abortion Service Facility					
Madhya Pradesh	Public		Private		Informal	
	Total Identified	Number who were providing the services and agreed to participate	Total Identified	Number who agreed to participate	Total Identified	Number who agreed to participate
Ujjain	11	6	42	25	75	75
Sidhi	22	5	26	26	95	95
Total	33	11	68	51	170	170

Since it was found during the mapping that informal providers constituted the major chunk of abortion providers in rural areas and even in some urban areas of both districts, we included 75 informal providers from Ujjain District and 95 from Sidhi District in the sample. Each nook and corner of the selected blocks in two districts was explored to list the informal/traditional providers using details maps to assist the logistics.

Tools Used and Data Collection

The Administration Schedule and Provider Schedule addressed the formal facilities and providers respectively. Except in the case of five facilities, the facility assessment data was collected through direct observation by the investigators, in the case of the 46 facilities, which agreed to provide this information. The schedule for informal providers addressed the issues of informal provision and was administered to such providers. The information for all schedules was collected by investigators through direct interviews. The researchers were on the field to supervise the investigators. They also made sure that the investigators had interviewed the concerned administrators/ providers and conducted more than random checking on the field. All the forms were checked in the evening of every fieldwork day and gaps or inadequacies in them were corrected with further visits to the facilities/ providers.

Selection and Training of Investigators

Out of the six investigators in the team, three were postgraduates in Social Work from Nagpur University, with some field experience. They were helpful in dealing with the doctors and collecting data, which had more social and economic bearing. Two female investigators were nurses with Diploma in General Nursing from Sulthania Ladies hospital, Bhopal.

The nurses assisted in collecting data on medico-technical aspects of abortion services, particularly in observing the equipment and instruments for facility assessment. For local support in the sample districts, two social activists from Bharat Gyan Vigyan Samiti (BGVS), Bhopal were selected. They were also trained as part of the investigators team.

Three day residential training was given to the investigators, prior to the fieldwork in each district using common guidelines and instruction manual. A detailed explanation of social, economic, medical, legal and ethical aspects of all the questions was provided during the training. The Project Co-ordinator for MP, explained the social, legal and ethical aspects of abortion, which were also implied in the schedules used for data collection. A Gynaecologist explained the medical and surgical processes and terminologies mentioned in the protocols. The gynaecologist also demonstrated and explained the functioning of various abortion related equipment and instruments to the investigators at Government hospital in Bhopal.

FINDINGS

Provision of Abortion

The provision of abortion services in the public sector is mainly concentrated in the urban areas. The PHCs, which are expected to provide the service to the rural women, are not offering it. No PHCs in the two sample districts of Ujjain and Sidhi were conducting abortion. Lack of an operation theatre or absence of a trained provider was cited as the reasons. Only 2 of the 4 CHCs in Sidhi were providing the service. In the developed district of Ujjain only a little over half of the public facilities which were supposed to provide abortion were doing so and in the less developed district of Sidhi only less than a quarter of them.

Formal private sector – registered and unregistered, as well as the informal sector provides the major chunk of abortion in the sample districts. Their participation in the study is dealt with in the introduction.

Certification

It was found that certification of facilities for conducting MTP was a cumbersome procedure. The mean time gap between application and registration was as long as 7.18 months and the mean number of times application was refused was 2.73. All this would have prevented even well equipped facilities with trained medical personnel also from applying for certification. This partly explains why as many as 71 % of facilities did not apply at all for certification. True, many of them may not have met the required criteria specified in the MTP Act 1971 and its Rules. But there could have been at least some facilities, which met the criteria, but did not want to go through the bureaucratic formalities of certification.

There is also a serious lack of adequate institutions to train doctors in abortion procedures. Training facilities are restricted only to the five Medical Colleges in Madhya Pradesh and just 8 district hospitals in the state, which has as many as 45 districts according to the Census 2001.

Reporting and Consent

All the public facilities and only 55% of the certified private facilities reported the MTP cases to the Government. All public facilities and an almost equally high 92% of private facilities took the consent of the women. Except in a little over one

third of private institutions the consent was written in all other institutions. Abortion procedure was mentioned in the consent forms of only 28% of private hospitals and higher 64% of public hospitals.

Although as per the MTP Act only the woman's consent was necessary for conducting abortions, no public institution would do it so. Among private institutions only 2 % would do abortions only with the woman's consent. Thus, in spite of legal sanction, the woman's right to abort is not culturally approved by the society. This social refusal of the woman's right to abort is getting reflected in the behaviour of the providers who seek the consent of the woman's husband and relatives in conducting abortions.

Physical Facilities Available in Institutions

Eighty nine percent of district, civil and other public facilities had visual and auditory privacy in the consulting room, while it was 100% among certified private facilities. In the case of uncertified private facilities the percentage for the two variables was relatively less than the other two categories of hospitals mentioned i.e. 67% and 50% respectively.

Place in Hospitals where MTP was done

Among the District hospital, civil hospital and other public institutions, which are supposed to have relatively better facilities, 11% conducted abortions in the out patient department. Twenty three percent of uncertified private facilities also conducted abortions in their consulting room. Eleven percent of District, civil and other public hospitals conducted abortion in the procedure room. Among the private facilities also 18% of certified and 27% of uncertified facilities conducted abortion in the procedure room. How the requirements of equipment, instruments and that of privacy could be met when abortions were conducted in OPDs and consulting rooms causes concern.

Equipment / Instruments

It was possible to observe the abortion related equipment & instruments in all the public institutions. But a comparatively low 82% and 88% of certified and un certified private institutions only allowed us to do so. Yet, this rate in the private sector is high, compared to some other states where the study is being conducted simultaneously. Our strategy of keeping the researchers rather inconspicuous and projecting the apparently young and unthreatening but trained investigators seems to have paid off.

Fifty percent of CHCs had shadow less OT lamp while none of them had adjustable focus lamp. Shadow less OT lamp was available in 67% of Dist/ Civil and other public hospitals and 73% of certified private facilities while only 21% of uncertified private facilities were having it. Eighty nine percent of other public facilities and 91% of certified private facilities had adjustable focus lamp, while 50% of the uncertified private facilities also had it.

Sixty seven percent of District/Civil/other public hospitals and certified private facilities had electric suction machine (ESM), whereas only 33% of not certified private facilities had ESM. Eighty nine percent of district, civil and other public hospitals and 67% of certified private hospitals had MVA syringe. Only 78% of district, civil and other public hospitals and 67% of certified

private facilities had at least 3 different sizes of MVA cannulae. The availability of MVA syringe, cannulae and adapters among the uncertified private facilities were 67%, 67% and 56% respectively. Among the CHCs only 50% had the above-mentioned instrument.

Hundred percent of certified private facilities and CHCs had Sim's/ Cusco's speculum, Tenaculum/ Volsellum, Ovum forceps, Uterine curette. The availability of these instruments among the District/Civil/ and other public facilities and certified as well as uncertified private hospitals were on the higher side: above 85%. Dilator set was available for 50% of CHCs and 78% of district, civil other public hospitals, while 67% of certified private facilities had the set. Compared to other categories 91% of uncertified private facilities had complete set of Dilators.

A higher percentage of public and certified private hospitals had most of the anaesthetic equipment. Among the district and other public hospitals, 89% had Oxygen cylinders, 78% had Boyles apparatus as well as laryngoscope. The first two of these equipment were not available in both the CHCs, which in fact would be the main contact point for the rural people, as PHCs were not providing abortions. Not even half of the non-certified providers were having, either Oxygen cylinders, Boyles apparatus or laryngoscope.

The public and certified private hospitals showed a higher percentage of availability of various sterilization equipment such as Steam sterilizers, formalin chambers & autoclaves. The corresponding percentages were low for the non certified facilities.

Availability of Drugs

Among the drugs used for inducing abortion or cervical priming, Ethcrydine was available in only up to or less than 50% hospitals in the four categories of hospitals. Prostaglandin injection was not available at 100% of CHCs (2). It was available at 78% of the Dist/ Civil and other public hospitals, and an equal percentage of certified private institutions. Its availability dropped to only 43% in non-certified private institutions. In the case of Oxytocin injection, except among the CHCs, where only 50% had it, the other three categories Viz. Dist/Civil and other public hospitals and the private institutions had a higher availability ranging from 89% to 100%.

Family Planning Devices

Tubectomy and IUD were the methods insisted by 71% and 74% of formally trained providers. Tubectomy scored the highest among the most preferred method of the providers. It appeared that commercial considerations and the primacy given to tubectomy in the Govt. health sector were influencing the providers in the private sector also.

Temporary devices of FP such as Oral Pills and Condom were also available in both the CHCs in the sample, while IUD was available only in one of them. Condoms were available at 100% of district & other public hospitals, while 89% of them had Oral Pills & IUDs. The pattern found in the district & other public hospitals was also seen in the certified private facilities. But non-certified institutions showed a low availability of all these devices. Since female sterilisation seem to be the preferred method of providers, the mere availability of spacing methods does not amount to their high utilisation.

Maintenance of Equipment

Only 10% of the institutions had taken annual maintenance contracts. It was highest among the District, Civil & public hospitals with 33% and lowest at 5% among the non-certified providers. Twentynine percent of institutions had to depend on other cities for getting their equipment repaired. The low level of AMC contracts coupled with the fact that a large percentage of institutions do not have the facility to repair their equipment in the cities where they are located raises concerns about the timely delivery of abortion services.

Availability of Service Providers

There was at least one or more full time gynaecologist with MD/ MS/ DNB in Gynaecology & Obstetrics or DGO in 73% of public facilities and 45% certified private institutions. Only 15% of non-certified facilities had full time gynaecologists. A small 9% & 13% of certified and non-certified private facilities had them visiting on specific days. Only 18% of uncertified facilities had full time MBBS doctors.

Provider Characteristics

There were 27% (19) public providers and 73% (52) private providers. Among them only 34% were MD/MS/ DNB in Gynaecology & Obstetrics or were DGOs. Trained providers with MBBS or MD/ MS in other branches were also only 16%. On an average the mean number of years of abortion practice of the providers was 13 years. The Mean age of the providers was 41.5 years, with a range of 24 – 65 years.

Training

Training in abortion was provided only at the 5 medical colleges in the state and eight district hospitals. The paucity of adequate training institutions also could be one of the reasons for the large number of untrained abortion providers in MP, who are catering to a market need, though improperly. In terms of qualifications, as many as 77% of the public providers were either MD / MS/DNB in Obstetrics & Gynaecology or DGOs. Among the private formally trained providers, only 44% had such qualifications. The presence of large percentage of highly qualified providers in the public sector could be one of the reasons for more referrals from the private to the public sector in the case of complications. At the same time it should not be lost sight of that in terms of numbers the private providers who amount to 73% of the providers could be having a wider reach than the public providers, who come to only 27%.

Gestations for which Abortion Done

On the whole most of the abortions were conducted within first 12 weeks of pregnancy. Sixty nine percent of the abortions conducted in CHCs were up to 12 weeks. Twenty percent of them were from 12-20 weeks and the rest 10% were for above 20 weeks. Only 19.67 abortions were conducted in a month in the two CHCs. On the contrary, in the District /civil and the other public hospitals 231.33 abortions were conducted in a month. Of them 69% were in the up to 12 weeks category and 31% were in the 12-20 weeks category. There were no abortions conducted in this group of hospitals for the above 20 week pregnancies. Among the certified private institutions, 79% of abortions conducted were in the up to 12 weeks category, 21% belonged to 12-20 weeks, while no abortions were conducted in the above 20-week category. In the non-certified institutions 95% of the abortions conducted were in the up to 12 weeks category. Four percent and 1% of abortions respectively were conducted in

the 12-20 weeks category and the above 20 weeks category.

Postponement / Refusal

In 46% of the public institutions, abortion was postponed at least once in the three months preceding the fieldwork. Such instances occurred in 31% of private institutions also. High Patient load was mentioned as one of the reasons by as high as 60% of public institutions. Non availability of the provider (40%), instrument related reasons (40%) and equipment disorder (20%) were the other reasons given by public institutions. In 50% of private institutions, equipment disorder was cited as the reason for postponement / refusal. Mean days of time lag due to repairs was as high as 11-37 days in different categories of public hospitals and 4 to 5 days in certified & non certified institutions.

Functioning at Nights

Eighty two percent of public facilities were open at night, while only 55% of private facilities did so. Doctors were available at night only in 46% of public facilities and a still less 41% of private facilities.

Managing Complications

The percentage of institutions, which handled in-house, the complications of abortion such as Excessive Bleeding, Perforation due to Peritonitis, Septicaemia, shock and infection was relatively higher in public than among private facilities. Immediate referrals after developing complications and referrals after stabilisation from private institutions ranged from 47% for shock to 59% for septicaemia. As regards management of post abortion complications, 82% of public institutions received cases of incomplete abortions, while only 59% of private institutions did so. Cases of Haemorrhage were taken in 73% of public institutions, while only 55% of private institutions treated them.

Referral Patterns

Majority (55%) of public institutions treated abortion patients in house, even when they developed complications, where as only 22% of private institutions did so. The four public facilities, which referred cases, did so for 2nd trimester abortions and medical risk cases. In the private sector also 87% and 79% facilities respectively referred cases of these two categories. Not surprisingly, a large 41% of private facilities referred abortion cases to the District / Civil or other public hospitals.

Other Reproductive Health Services

Several Reproductive Health Services were provided by around 90% of both public and private facilities. Other Gynaecological problems were attended to in only 33% of private institutions, while 82% of public institutions were attending to them. Vaginal procedures were conducted in 51% of private institutions while 73% of public institutions did so. In the case of Laparotomy and Lapraroscopy the variation between public and private institutions is very wide. Laparotomy: public – 55% and private 22%. Lapraroscopy: Public –73% and private – 12%.

Techniques Used & Pain Control

For abortions up to 8 weeks many of the formally trained providers used D&C (38%) and Manual Vacuum Aspiration (MVA). Several of the not formally trained providers used D&C (50%). In the case of abortions between 9-12 weeks, large number of formally trained providers used D&C (45%) while 58% of not

formally trained providers also used the same method.

Only 36% of formally trained providers and 15% of not formally providers were conducting second trimester abortions. Majority of formally trained providers i.e. 53% used D&C for second trimester abortions. Intra Amniotic 7.1% and Extra Amniotic 5% methods were also used by a small number of formal providers.

Pain Control Methods

To control the pain of abortions up to 8 weeks 93% of formally trained providers used analgesics and sedatives, while local anaesthesia was also used by 67% of them. The pattern was the same with reduced percentage for the not formally trained providers also: 58% and 42% respectively.

In the case of 9-12 weeks abortions 79% of formal providers used analgesics and sedatives, while 67% also used local anaesthesia. General anaesthesia was used by 14% of formally trained providers. Half of the not formally trained providers used analgesics and sedatives for 9-12 weeks abortions, while local anaesthesia was used by 42 % of them.

Analgesia & sedatives and General Anaesthesia were used for pain control for second trimester abortion by majority of formally trained providers. The respective percentages for formally trained providers were Analgesics & Sedatives 73% and General Anaesthesia 53%. While 75% of not formally trained providers also used analgesics, sedatives and local anaesthesia, all of them used general anaesthesia .

It appeared that only few providers were doing abortions above 20 weeks, which is not legally sanctioned. Among the two formally trained providers who were doing abortions for above 20 weeks, one was using local anaesthesia, while both used analgesics and sedatives. One not formally trained provider was using only local anaesthesia.

Pre discharge Examination

General physical examination was conducted by large majority of the formally trained i.e, 98% and not formally trained providers i.e, 81%. Pelvic examination was done by 60% of formally trained providers, while only 23% of not formally trained providers conducted it. Abdominal examination was conducted by 45% of formally trained, while only 31% of not formally trained providers conducted it.

Pre & Post Abortion Counselling & Follow Up Advice

As per the responses received from the providers, all formally trained providers and 96% of not formally trained providers were providing pre and post abortion counselling. Excessive bleeding, abdominal pain and vomiting were the conditions for which follow up was advised by 95%, 91% & 71% respectively of formal providers. Ninety six percent of not formally trained providers advised follow up for excessive bleeding, while 81% of them advised for abdominal pain. It is true that the above responses of providers for pre and post abortion counselling amount to very high claims by the providers. Such a high positive response regarding counselling could be doubted. But since the survey method is based on the stated responses of the research participants, this is a limitation of the study.

Contraceptive Counselling

All the 42 formally trained providers (100%), offered contraceptive counselling, while this percentage was slightly less at

89% with the not formally trained providers. Majority i.e. 60% of formally trained providers offered contraceptive counselling before the procedure, while 46% of not formally trained also did so. Fourteen percent of formally trained and 27% of not formally trained providers gave counselling on contraception after the procedure.

Insistence of the providers that the women adopt certain Family Planning methods amounts to coercing the women, when they are in a vulnerable situation, seeking the providers help in getting an abortion done. As high as 95% of formally trained providers insisted on the FP method, while a slightly less 77% of not formally trained providers also did insist on it. Tubectomy and IUD were the methods insisted by as high as 71% and 74% respectively of formally trained providers. On the contrary, probably due to the lack of technical knowledge of conducting tubectomy, only 50% of not formally trained providers insisted on Tubectomy. IUDs, Pills and Condoms were the methods insisted on by 62%, 65% and 58% of not formally trained providers.

Access to Abortion Services

Eighty two percent of public and 91% private facilities were situated on the roadside or close to it. Bus service was available to reach 91% of public and 69% of private facilities.

Cost of Services

Seven of the 11 public facilities charged an average maximum amount of Rs. 286 for abortions of 12 week old pregnancies and 2 facilities charged an average maximum amount of Rs.775 for abortions up to 20 weeks. We doubt on the basis of information from the field that in the case of many public institutions, these are partly or fully private payments to the concerned providers in the public sector and are not fully user charges. The cost of abortion in private facilities for different gestational periods was considerably higher. The average maximum cost of MTP service in private sector for up to12 weeks gestation and up to 20 weeks were Rs.559 and Rs.1321 respectively.

Out of 51 private facilities only 3 were providing MTP service for above 20 weeks. The mean maximum cost of MTP for above 20 weeks in private facilities was Rs. 1583. The range of maximum cost in private sector varied from Rs.1000 to Rs. 2250.

Facilities with Female Providers

Seventy three percent of public facilities were having at least one female abortion provider, while 55% of private facilities were not having even one woman provider.

Circumstances under which Facilities Provide Abortion

According to the MTP Act 1971, certified facilities are expected to provide abortion even if a woman came alone. Out of 11 public facilities, 27% said that they would provide abortion service even if a woman came alone. In the private sector also 36% of certified facilities said that they provided the service if women came alone. The percentage of uncertified private facilities offering MTP service, even when a woman came alone was reasonably higher than for the other two categories i.e. 42%. But it could be that this was more of a market driven decision in order to attract clientele. In case a woman came with a friend but not with any family member, 82% of public facilities and 55% of certified private facilities would provide abortion, while

70% of uncertified private facilities also would offer the service. Even though a section of the providers in the public and private sectors are saying that they provided abortions to women who came alone this does not seem to reflect their actual practice, which is reflected in their response on consent taken presented under Reporting and Consent.

From what appears from the responses of our research participants, the unmarried women would find it more difficult to get abortion done, compared to widowed or separated women. Hundred percent of public facilities and 73% of certified private facilities would offer MTP service if the woman was a widow/separated or nullipara. Seventy three to eighty percent of uncertified private facilities would also offer the service in that case. But in the case of the woman who was unmarried only 36% and 50% of certified and uncertified facilities respectively would offer the service, while a higher 73% of public facilities claimed that they would offer the service in that case also.

Provision of Abortion by Informal Providers

Profile of the Informal Providers Interviewed

There was a conspicuous presence of males among the informal providers, with 59 male providers as against 16 females in Ujjain district and 72 males as against 23 females in Sidhi district. Altogether there were 77.5% males and 22.95% females in the overall sample of 170. RMPs or Village Practitioners formed the major chunk of informal providers in both districts. Out of the 170 informal providers 113 i.e. 67.47% were RMPs / Village Practitioners. As the number of female abortion providers was very low, there were only 17 ANMs and 2 Nurses amounting to just 11%. RMP-hood, to which the males could upgrade themselves more easily, given the general perception of the doctor as a male in rural areas, seems to have emboldened many men to take to provision of abortion.

Treatment of Delayed Periods by Informal Providers

All informal providers (100%) interviewed were treating delayed periods. Nearly two-thirds of female informal providers i.e. 64%, used instruments to induce abortion while only 41% of males mentioned that they used instruments. We felt that the male informal providers were generally reluctant to admit the use of instruments. Fiftyeight percent of male informal providers and 46 % of female informal providers also claimed that injections were successful in more than fifty percent of cases.

Instrumental Intervention to Bring on an Abortion

Out of 54 male informal providers who used instruments, 46% of them used sharp metallic instruments, while 72% of female informal providers who used instruments were using Curette / D&C for inducing abortion. Thirtynine and 34% of male informal providers used Curette/D&C and Syringes respectively. Around 26% to 28% of male and female informal providers used catheter for inducing abortion.

Among the male informal providers, the mean gestation period for which uterus evacuation was done using instruments was 8.3 weeks, with a range of 1-20 weeks. Correspondingly the mean gestation period for which the female

informal providers used instruments was 9.3 weeks with a range of 1-23 weeks.

The male informal providers treated an average of 2.2 cases per month with instruments, while a slightly higher average of 3.7 cases per month were treated using instruments by female providers. Both the categories got cases within a range of two to thirty per month.

Other services provided by informal providers

The range of other services provided by informal providers was vast. Ninetytwo percent of informal providers gave injections for various other illnesses. A good number of providers treated sprains/ fractures and did sutures also. Sixty seven percent of providers attended deliveries. Among them 62% claimed that they conducted even complicated deliveries with breach presentation and excessive bleeding! More than ninety percent of informal providers claimed that they handled cases of incomplete abortions as well! Menstrual problems were attended to by almost all ie, 99% of them.

1. INTRODUCTION

1.1. Background

The Medical Termination of Pregnancy (MTP) Act of 1971, which came into effect on 1st April 1972, was supposed to relax the abortion law in India and regulate doing abortions for a wider set of reasons. Prior to the enactment of this legislation, the Indian Penal Code (Act No. 45 of 1860) permitted abortion only when it was justified for the purpose of saving the life of the woman. Article 312 of the Penal Code provided that any person performing an illegal abortion was subject to imprisonment for up to three years and /or payment of fine, if the woman was "quick with child" the punishment was imprisonment for up to seven years and payment of a fine. The same penalty applied to a woman who induced her own miscarriage (United Nations, 2001).

The MTP Act of 1971 had the effect of allowing abortions to be performed under grounds other than specified in the Penal Code. Under the 1971 Act, a pregnancy could be terminated on medical grounds when the pregnancy endangered the life of the woman or caused grave injury to her physical or mental health or on eugenic ground, when the foetus was developing serious handicaps due to physical or mental abnormalities or on humanitarian grounds where pregnancy was caused by rape and also on social grounds when pregnancy was caused due to failure of contraceptive devices or methods (MTP Act 1971).

A pregnancy may be terminated on the above grounds within the first 12 weeks of gestation on the opinion of one registered medical practitioner. If the pregnancy had grown for more than 12 weeks, but less than 20 weeks, two registered medical practitioners must be of the opinion formed in good faith that the required grounds existed. An abortion could be performed only by a registered medical practitioner in a hospital established or maintained by the Government or in a facility approved by the Government. Only the consent of the woman is required for conducting abortion in the case of major women. Written consent of the guardian of a woman is

required in the case of minor and mentally retarded women (MTP Act 1971).

The Government of India had enacted the MTP Act of 1971, with the intention of reducing the incidence of illegal abortions and the consequent maternal mortality and morbidity. However, implementation of the Act has been slow and geographically uneven. U.N. observes: "abortion services are often inaccessible and women are reluctant to utilise those services because of the lack of anonymity and confidentiality. Therefore, the number of illegal or unregistered abortions performed by medical or non-medical practitioners is still very high. The level of awareness of the legality of the procedure is fairly low, and the existing facilities for the legal medical termination of pregnancy are either not available or are not utilised by many women who seek illegal abortions" (U.N. op. cit 2001).

The registration requirements of the MTP Act 1971 restrict access to abortion care. The Act also leaves room for interpretations against women's interests. It empowers the medical profession to make judgements on the need for abortion vis a vis the women. Abortions up to 12 weeks have to be authorised by one registered doctor, while those from 12 to 20 weeks have to be authorised by two such doctors. In this process the Act enjoins the doctors to take " the pregnant woman's actual or reasonable environment " into consideration. A pregnancy following rape or failure of contraception for married women and possibility of having a child with physical, mental abnormalities are also cited as grounds for authorising. But the Act does not specifically recognise the woman's right to abort unwanted pregnancies. Though the Act does not stipulate, in practice the providers demand the husband's consent and signature for the wife's abortion. The Act does not provide for mechanisms to ensure the regular maintenance of quality standards of abortion either. These and other related anomalies in the provision of abortion services can be corrected in an enduring manner, only by basing abortion services on an expanded access to health care, increasing female literacy and by ensuring measures for women's empowerment (Jesani A & Iyer A 1993 and Chayanika & Kamaxi, 1999).

Despite the relaxation of the abortion law in certain respects, unsafe

abortions have contributed to the high rates of maternal mortality in India. According to Sample Registration Survey (SRS) of 1998, 8.9 percent of all maternal deaths were (407 maternal deaths per 100,000 live births) due to unsafe abortions i.e. 9000 to 10,000 maternal deaths per year and many women were impaired permanently by complications (UN 2001 op. cit).

1.2. Rationale

Though the MTP Act 1971 has legalised abortions with the consent of only the woman, the necessary facilities for conducting abortions are not adequately available in the public or the private sector. While in the public sector several facilities, which are supposed to provide the service, are not providing it, the availability of providers with the necessary training and institutions with the required registration under the Act is very limited. The training facilities for imparting training in MTP are also limited in number. This has given rise to a lack adequate facilities and providers for conducting safe abortions and to the mushrooming of unregistered facilities and untrained providers who conduct abortions, causing concerns of quality and safety. In addition to unregistered providers with formal qualification in one or other stream of medicine who are conducting abortions, the informal providers who do not have any formal qualifications are also conducting abortions. The study intends to look into the provision of abortion services in detail and to come up with findings which would facilitate making necessary changes in the registration, training, quality of abortion service and to improve the provision of the service in such a way that it benefits the end user: the woman seeking abortion. With this end, the study has the following objectives, which are listed below, as a sub section.

The state of MP was selected for the study based on an analysis of the women's health and related indicators of states of India and MP's score in it. The indicators selected for this ranking included institutional deliveries, maternal mortality ratio, neonatal mortality rate, female infant mortality rate, couple protection rate, total fertility rate and female literacy rate. The indicators of the pre-divided state of MP before the passage of the Chattisgarh formation Bill was taken into consideration. The scores of different

states were aggregated under four clusters. The combined state of MP was ranked along with UP and Rajasthan as fourth category state i.e. in the lowest cluster.

1.2.1. Objectives

The study intends to understand and analyse issues related to the provision of abortion services in public and private sectors, which have bearing on users as well as providers. These issues are mentioned below:

- Management of abortion services including management of complications & life threatening situations.
- Technologies used
- Registration, training and certification
- Availability, technical competence, training needs and current training facilities/ programmes for abortion care providers
- Utilisation of facilities
- Adequacy/ appropriateness of the MTP Act from the providers perspective
- Costing and Finance related issues

1.3. Study Area

1.3.1. Profile of MP and the Sample Districts

Madhya Pradesh (MP) is one of the states selected for the study on abortion providing facilities based on various criteria of development and female health status. M.P is located at the geographic centre of India. It shares its border with seven states, namely, Maharashtra, Gujarat, Rajasthan, Uttar Pradesh, Bihar, Chattisgarh and Andhra Pradesh. As per 2001 Census Madhya Pradesh is the second largest Indian state in terms of area and accounts for 5.9 percent of India's population.

Agriculture continues to be the core of the economy of the state, while industrialisation is limited to selected pockets neighbouring the state's metropolitan towns. In spite of industrial advance, there is little diffusion of development to rural and remote areas. According to the Planning Commission, 41 percent of the rural and 48 percent of the urban population in Madhya Pradesh were below the poverty line in 1993-94 (CSO, 1999 in NFHS- 2, M.P.1998-99).

According to the 1991 Census, Madhya Pradesh had a population of 66.2 million. In 2001 Census the population of MP is 60.3 million. This decrease is due to the bifurcation of state into MP and Chattisgarh. As per the 1991 Census, the proportion of the total scheduled caste

population was slightly lower in Madhya Pradesh (14 percent) than in India as a whole (16 percent). The state, however, had the highest percentage (23%) of Scheduled Tribe population in the country outside the north- eastern states. The Schedule Tribe population in Madhya Pradesh increased from 20 percent of the total population in 1971 to 23 percent in 1991. This percentage is also likely to undergo a decrease, as many districts with tribal concentrations have become part of the Chhatisgarh state. The 2001 Census data on Schedule Caste and Schedule Tribes are not yet published. This data is likely to bring out the decline of ST population in MP.

Madhya Pradesh is one of the educationally backward states in India according to the 2001 Census. The literacy rate for M.P. was 64.09 percent slightly less compared to 65.3 percent for India as a whole. The literacy rate was 76.50 percent for males, and 50.55 percent for females in Madhya Pradesh compared to 75.85 percent and 51.16 percent for males and females, respectively, for India (Census of India 2001 M.P.). Though the female literacy rate is slightly higher than all India rate, there is a large gap between male and female literacy rate in M.P.

In terms of other demographic indicators too, Madhya Pradesh performs poorly in relation to many other states. According to the Sample Registration System (SRS) 2000, the crude birth rate for MP was 33.4 per 1,000 population in rural areas and 23.5 per 1000 in urban areas. The crude death rate was 11.1 per 1000 in rural areas and 7.5 per 1000 in urban areas (SRS 2000). These figures ranked extremely low compared to the corresponding national figures. According to SRS 1997 the total fertility rate for M.P was 4.0 children. As per NFHS the TFR for MP was 3.31 children. The life expectancy in the state was 54.7 for males and 54.6 for females for the period of 1991-95, which is less than the corresponding figure for all of India, 59.7 for males and 60.9 for females (*NFHS-2 - MP.1998-99*). Twenty eight percent of urban women and 58 percent of rural women in the age group of 20-49 got married at the age of 15 in M.P. In the same age group 12% women in the urban areas and 34% in the rural areas married as early as 13 years *(NFHS- 2, 1998-99).*

The districts of Ujjain and Sidhi have been selected for this study based on various criteria. The details of district selection are mentioned in the section on research methodology elsewhere in this chapter.

1.4. Abortion Situation in Madhya Pradesh

1.4.1. Legal Position of MTP Act in M.P.

As per the information received from the Department of Health and Family welfare, M.P., the state Government had not made any changes in the MTP Act, 1971 enacted by the Union Government. The state Government follows the same Act of 1971 and its Rules made by the Central Government.

1.4.2. Number of Institutions Providing Abortion Service in M.P

According to the information collected from the Department of Health and Family Welfare M.P., this State has 210 Govt. facilities and 144 private registered facilities providing abortion. Though the number of registered private abortion providing institutions is relatively low, a large number of unregistered providers also co-exist as we found in our fieldwork. In some districts like Sheopur, Umaria and Dindori no private or Government facilities are offering abortion service. In Chindwara district there are 6 private facilities while no Government facility is offering abortion service. There are districts with one Government facility for the entire district. District wise distribution of Government and private abortion providing institutions is given below **(See Table 1).**

Table 1: No. of Govt. and Registered Private Institutions Providing MTP Services in M.P.

S. No	Name of the District	Private 2001-02	Govt. 2001-02
1	Morena	1	4
2	Bhind	Nil	1
3	Sheopur	Nil	Nil
4	Gwalior	14	7
5	Datila	Nil	6
6	Shivapuri	3	1
7	Guna	1	11
8	Tikamgarh	1	3
9	Chhatrapur	1	10
10	Panna	Nil	1
11	Sagar	3	1
12	Damoh	2	2
13	Sathna	3	10
14	Rewa	2	11
15	Shahdol	1	3
16	**Sidhi**	**Nil**	**3**
17	Umaria	Nil	Nil
18	Mandsaur	5	5
19	Ratlam	4	6
20	**Ujjain**	**5**	**11**
21	Shajapur	Nil	1
22	Dewas	Nil	5
23	Neemuch	Nil	4
24	Jhabua	Nil	3
25	Dhar	2	8
26	Indore	22	12
27	Khargone	Nil	Nil
28	Khandwa	5	16
29	Barvani	Nil	7
30	Rajgarh	Nil	7
31	Vidisha	6	2
32	Bhopal	34	3
33	Sehore	1	5
34	Raisen	Nil	8
35	Bethul	3	3
36	Hoshangabad	1	4
37	Harda	Nil	3
38	Jabalpur	16	5
39	Narsimhapur	Nil	4
40	Mandla	Nil	6
41	Chindwada	6	Nil
42	Seoni	1	3
43	Balagaht	1	9
44	Katni	Nil	1
45	Dindori	Nil	Nil
	Total	**144**	**210**

Source: Department of Health and Family Welfare, Secretariat, Bhopal, 2002

1.4.3. MTP Training Centres in Madhya Pradesh

The training facilities in MP for doctors who want to get trained in providing abortion is very limited for this large state. According to the information received from the Department of Health and Family Welfare, MTP training is provided to doctors only in the 5 Medical Colleges of the state and 8 of the state's District Hospitals. Two more district hospitals, which were MTP training centres became part of the newly constituted Chhattisgarh state, which was carved out of MP. The MTP training centres in the present state of M.P. are given in table below **(See Table 2).**

Table 2
Medical Termination of Pregnancy Training Centres in M.P.

S. No.	Medical Colleges	District Hospitals
1	Bhopal	Bhopal
2	Indore	Guna
3	Gwalior	Barwani
4	Jabalpur	Jabalpur
5	Rewa	Satna
6	-	Sagar
7	-	Mandsaur
8	-	Ujjain

Source: *Department of Health and Family Welfare, Secretariat, Bhopal, 2002*

As per the interview with the Deputy Director of Family Welfare and Health, Secretariat, Bhopal, on, 20th Sept. 2002 the duration of MTP training was for fifteen days. Gynaecologists of respective Medical Colleges or from the District Hospitals gave the training. Training at the centres was provided only to doctors with MBBS or MD in allopathy. The interested doctors could send applications, which were issued from the department of Health and Family Welfare to the Chef Medical Officer of the district, based on which they were selected.

In an interview with a senior gynaecologist of Ujjain district hospital on 20th April 2002, she mentioned that individual training was given to doctors in all surgical methods of abortion. Twenty five MTP cases had to be performed by the doctor during the training period. Training at these centres was available for private and public doctors free of charge.

1.4.4. Number of Abortions Done in Govt. Institutions in M.P. (April1998 to August 2002)

The following table gives information on the abortions done in Government facilities of Madhya Pradesh during the period of 1998-99, 99-2000, 2000-01 and April 2002 to August 02. Reporting of MTP from private facilities is rather improperly done and therefore the data of private institutions are not available. In 1998 - 1999 the total number of abortions done in Govt. facilities in M.P was 25354 and in Ujjain and Sidhi the sample districts for this study 849 and 302 respectively. By the year 2000, ten thousand more abortions were done in Govt. centres in the state, which amounted to 35451. In Bhopal district alone it increased to 4226 from 2107. In 2000-01 a slight decrease is seen in the number of abortions conducted in Govt. centres, throughout the state. Ujjain and Sidhi districts also showed a decrease in abortions during this period from 779 to 627 and 459 to 190 respectively. The statistics from April 2002 to August 2002 was available according to which in Ujjain district 180 abortions and in Sidhi 13 abortions were done in Govt. centres **(See Table 3).** The decline of abortions from 2000-01 onwards could be due to decline in sex selective abortions, due to the impact of the PNDT Act, which prohibits pre natal testing for identifying the sex of the foetus and thus attempts to prevent female foeticide.

Table 3: Number of MTPs Conducted in Govt. Facilities from 1998 to August 2002

S. No	District	1998 – 999	1999-2000	2000-2001	April 2002 to August 02
1	Morena	310	694	1271	550
2	Bhind	429	328	315	166
3	Sheopur	-	80	11	Nil
4	Gwalior	1728	1757	2008	654
5	Datia	229	261	301	76
6	Shivpuri	346	396	249	47
7	Guna	874	903	785	85
8	Tikamgarh	411	557	479	248
9	Chhatarpur	744	1020	1235	525
10	Panna	498	786	995	182
11	Sagar	390	384	519	260
12	Damoh	1305	2018	2050	594
13	Satna	664	903	973	311
14	Rewa	821	788	970	341
15	Shahdol	585	618	631	216
16	**Sidhi**	**302**	**459**	**190**	**13**
17	Umaria	N Av	36	9	Nil
18	Mandsaur	920	610	591	214
19	Ratlam	236	1322	586	*71*
20	**Ujjain**	**849**	**779**	**627**	**180**
21	Shajapur	82	252	171	37
22	Dewas	915	1400	1035	283
23	Neemuch	N Av	217	353	82
24	Jhabua	170	995	671	131
25	Dhar	1275	2549	2212	962
26	Indore	1264	2028	2106	828
27	Khargone	N Av	484	488	71
28	Khandwa	148	195	138	30
29	Barwani	1288	785	730	180
30	Rajgarh	26	270	459	260
31	Vidisha	217	206	127	45
32	Bhopal	2107	4226	1878	717
33	Sehore	1196	904	852	387
34	Raisen	174	152	229	80
35	Betul	885	886	789	298
36	Hoshangabad	1023	696	481	133
37	Harda	N Av	653	574	230
38	Jabalpur	1125	1288	1081	293
39	Narsimhapur	475	757	593	275
40	Mandla	542	620	676	208
41	Chhindwara	251	205	254	79
42	Seoni	462	688	787	253
43	Balaghat	88	231	354	105
44	Katni	Nil	29	Nil	15
45	Dindori	Nil	36	39	15
	Total	**25354**	**35451**	**31872**	**10763**

Source: Department of Health and Family Welfare, Secretariat, Bhopal, 2002

1.4.5. Status of Prenatal Diagnostic Testing and Sex Selective Abortions in Madhya Pradesh

The strong preference for sons under the patriarchal tradition and the availability of prenatal diagnostic techniques at the foetal and even embryonic stages have resulted in an increased use of this technique for determining gender during pregnancy and doing sex selective abortions of female foetuses (George S. 2003). According to the NFHS-2 data the women in M.P. showed a strong preference for sons than daughters. Apparently the percentage who wants more sons than daughters was only 29.5 in urban areas and was higher at 47 in rural areas *(NFHS- 2 1998-99, pp 88-89).*

However the under six-sex ratio of 2001 census in MP tells a different story. According to the Census, 0-6 sex ratio for MP as a whole is 941 per 1000 males for rural areas and a lesser 906 per 1000 males in urban areas (Census 2001). Thus a relatively lower preference for sons in urban areas of the state expressed by the respondents of the NFHS-2 is not supported by the actual under-6 gender data of the Census. It can be observed from district level census data of MP, that only in three districts viz.Tikamgarh, Mandsaur and Bhopal was the sex ratio of under six children slightly higher in the urban areas than the rural areas. In the sample districts of Ujjain and Sidhi also the sex ratio was low in the urban areas compared to rural areas. In Ujjain it was 946 per 1000 males in rural areas, as against 908 per 1000 in urban areas. In Sidhi the ratio was 957 per 1000 males in rural areas as compared to 902 per 1000 in urban areas (Census 2001). It appears that the higher availability of facilities for sex selective abortions in the urban areas could be a reason for the lesser sex ratio found in the urban areas of most of the districts of MP compared to rural areas.

To curb this practice, the Government of India enacted Prenatal Diagnostic Test (Regulation and Prevention of Misuse) Act 1994, shortly known as PNDT Act, which regulates testing in this regard. The stated rationale of the legislation is to forbid the use of prenatal diagnostic techniques for the determination of the sex of foetuses, which resulted in female foeticide. To this end, the law restricts the performance of prenatal diagnostic testing to cases involving serious diseases and abnormalities and prohibits entirely the

use of such techniques to determine the sex of a foetus and the advertising for that purpose. Facilities performing such techniques must be now registered, and persons conducting the testing in these facilities are prohibited from revealing the sex of a foetus in any manner. The law also prohibits family members of a pregnant woman from seeking or encouraging her to undergo prenatal testing to determine the sex of the foetus. Penalties for contravening the provisions of the law include imprisonment and fines and, in the case of a registered medical practitioner, loss of registration, which can be permanent in the case of repeated offences *(PNDT Act 1994).*

The implementation and monitoring of PNDT Act in M.P. is presented in **Appendix I as Table No. I.** As per the table, M.P. has 650 private institutions registered for conducting the Prenatal Diagnostic Test, under the PNDT Act. Among the districts, Indore and Bhopal, two of the most developed and urbanised districts of the state, have 127 and 107 private facilities respectively. The number of private hospitals registered under PNDT Act is higher than the facilities registered under the MTP Act. Ujjain and Sidhi, the sample districts for the study, have 25 and 6 private facilities providing PNDT respectively. In Ujjain district it appeared that the PNDT Act was strictly implemented. In many parts of the city hoardings and posters warning against misuse of PNDT were seen during our fieldwork. In many districts of MP some of the facilities, which misused the test, were either banned, sealed or their registration cancelled. This indicates that the state Government was keen to give an impression of having a strict vigil on the facilities, which were doing PNDT. For details see the **(See Table I in Appendix I).**

1.5. Research Methodology

1.5.1. Sampling

1.5.1.1. Selection of Districts

As per the requirement of the study two districts from Madhya Pradesh were selected as follows. For each district the values of six variables- *sex ratio, percentage of institutional deliveries, female IMR, female literacy, total fertility rate (TFR) and couple protection rate (CPR)* were identified and the districts were ranked for each variable. The ranks were added up to arrive at a composite score for each district, and the district with

the lowest composite score, scored rank one and so on. Once the districts were ranked, they were divided in to four quartiles and one district each from the top and the bottom quartile were selected, excluding the top and the bottom ranked districts as outliers. Ujjain district as second most developed and Sidhi district as second least developed were selected from the highest and the lowest quartiles **(See Table 4).**

At the time of selecting the sample districts, the state was still undivided and therefore all the districts in the undivided state have been taken into consideration for the district ranking. Still we find that the two districts of Ujjain and Sidhi, which are part of the truncated state of MP, match all the criteria of sample selection. In Madhya Pradesh many new districts and blocks were created in the last few years and hence the selection of districts was restricted to the old districts.

The preliminary data required for ranking districts of Madhya Pradesh such as data on sex ratio, female literacy, total fertility rate, female IMR, were collected from Census of India 1991. Percentage of institutional deliveries and Couple protection rate were collected from RCH District Level Data. The data based on which the districts are ranked are given in the Appendix **I as Table No. II**

Table 4: MP District Level Ranking (Arranged in Descending Order)

Rank	District	Female Sex Ratio	Female Literacy Rate	Total Fertility Rate	IMR –91 (Female)	Couple Protection Rate	Institutional Deliveries	Composite Score
		1	2	3	4	5	6	
1	Indore	27	2	1	1	1	1	33
2	**Ujjain**	**20**	**11**	**7**	**2**	**5**	**4**	**49**
3	Durg	9	4	9	3	9	17	51
4	Bhopal	32	1	18	8	3	2	64
5	Mandsaur	16	18	6	15	14	10	79
6	Dewas	21	24	20	9	4	5	83
7	Narsimhapur	26	6	3	20	6	22	83
8	Balaghat	2	7	2	30	13	30	84
9	Jabalpur	25	3	14	18	21	6	87
10	Seoni	8	14	10	19	11	26	88
11	West Nimar	14	27	25	22	NA	NA	88
12	Gwalior	41	5	19	10	10	3	88
13	Ratlam	15	17	16	26	7	7	88
14	Betul	10	10	31	28	2	11	93

15	Mandla	5	28	5	11	12	33	94
16	Raigarh	3	23	4	13	34	20	97
17	Chhindwara	12	12	27	17	10	20	98
18	Hoshangabad	29	9	15	27	15	5	100
19	Rajnandgaon	1	20	8	22	19	34	104
20	Bilaspur	6	21	17	5	32	27	108
21	Raipur	4	15	12	21	24	32	108
22	East Nimar	18	13	28	25	10	15	109
23	Dhar	13	32	21	9	16	23	114
24	Bastar	2	40	13	4	31	31	121
25	Shajapur	24	35	22	19	20	8	128
26	Surguja	11	38	11	6	35	31	132
27	Sagar	33	8	32	26	23	12	134
28	Sehore	30	29	30	18	18	13	138
29	Vidisha	36	20	34	9	26	18	143
30	Shahdol	17	33	23	14	29	32	148
31	Jhabua	7	42	37	7	40	21	154
32	Rewa	19	22	35	23	28	29	156
33	Damoh	28	16	26	27	25	36	158
34	Datla	40	26	24	28	27	13	158
35	Bhind	43	19	34	16	22	25	159
36	Raisen	34	25	40	33	8	24	164
37	Satna	24	20	33	30	32	28	167
38	Rajgargh	22	39	29	29	34	20	173
39	Tikamgarh	37	34	41	32	17	16	177
40	Guna	35	37	38	29	30	8	177
41	Morena	42	31	42	17	38	9	179
42	Shivpuri	39	39	31	27	33	14	183
43	Chhatarpur	38	30	34	31	37	19	189
44	**Sidhi**	**23**	**41**	**39**	**12**	**39**	**37**	**191**
45	Panna	31	36	36	24	41	35	203

Sources 1-4: *Census of India 1991 Fertility and Mortality Indicators at the District Level, 1997*
5-6: *RCH District Level Data*

1.5.1.1a. Ujjain District

Ujjain district is situated on the South - Western part of Madhya Pradesh. The district is bounded by Shajapur district, extending from north to east; by Ratlam district extending from north to west and by Dhar, Indore and Dewas districts on the South. Ujjain has a great cultural heritage and is historically important.

The first historical notice of Ujjain city and the tract comprising Ujjain district dates from the rise of the Mauryas in the 3rd Century B.C. In the Mauryan Empire, Ujjain took its position as the natural capital of the Western half of the empire. In the Gupta period of 4th – 6th centuries AD and particularly during the region of Chandragupta Vikramaditya from 375 AD to 415 AD, Ujjain was a great centre of art

and culture. Ujjain was the capital of Vikramaditya. The famous Sanskrit dramatist Kalidasa wrote his poetical plays as a member of the *Navaratnas* in Vikramaditya's court (Thapar R.1983 and Kosambi DD, 1981).

Later Ujjain was also part of the Mughal Empire and subsequently came under the Gwalior State of the Scindhias. After India became independent the rulers of Gwalior signed a covenant on 22nd April 1948 with Union Government and became part of the Madhya Bharat state *(Census of India 1991, M.P. Ujjain)*. The famous Siva temple at Ujjain has one of the twelve *Jyothirlingas* of the country as its idol. Ujjain can also boast of one of the *Jantar Mantars* in India. Administratively at present Ujjain is divided in to six blocks viz. Kacharod, Mahidpur, Ghatiya, Tarana, Ujjain and Badnagar. Ujjain is the headquarters of the division and the district. Ujjain block is also a Municipal Corporation.

1.5.1.1b. Sidhi District

Sidhi, the less developed district, is located in the North – eastern part of Madhya Pradesh. Borders of Sidhi touches Sonabhadra and Mirzapur districts of U.P. in the East, Shahadol district in the South, Satna district in the West and also touches Rewa in the North. It is 632 km. by road from Bhopal to Sidhi and 80 km from the Divisional Headquarters at Rewa *(IPDP-UNFPA, 2001)*. The extremely inhospitable eighty kilometre road, from Rewa to Sidhi, through the Vindhyachal mountains is full of steep climbs and deep declines and is surrounded by jungles at many places.

In the Baidhen block of Sidhi District, the Singrauly coalmines, the power plant of National Thermal Power Corporation (NTPC) and Pant Sagar Project are situated. The district is interspersed with green hills, deep valleys and dusty kutcha roads which pass through them. Forests occupy a good part of the district. Administratively Sidhi is divided in to 8 blocks, Rampur Naikin, Gopandbanas, Sihwal, Chitrangi, Deosar, Majholi, Kusmi and Baidhan.

1.5.1.2. Selection of Blocks

The blocks were first ranked according to their urban population percentage. The ranked blocks were then divided into three groups, one group that was closest to the average urbanisation percentage of the district, another group, which had blocks above the district urbanisation percentage

and the third group below the average level of urbanisation.

Ujjain District with an urban population of 38.74% has 6 blocks. As per the method mentioned above, the blocks were ranked according to their urban population percentage. Kacharod block, having 39.35% urban population was selected as the block, which was closest to the district urbanisation percentage. Ujjain block with 76.40% urbanisation was selected as the block with the above average urbanisation percentage and Tarana block with 9.87% urbanisation was selected as the block with the below average urbanisation percentage. The block of Kacharod, which was identified as closest to the average block, is divided into two tehsils, Kacharod and Nagda **(See Table 5).**

Table 5: Blocks in Ujjain District – Some Indicators

State/ District/ Blocks	Total Rural Urban	Population- 2001			Female Literacy Rate	Sex Ratio	% of Urban population
		Persons	Males	Females	2001	2001	2001
MADHYA PRADESH	Total	60385118	31456873	28928245	50.55	920	26.67
	Rural	44282528	22975256	21307272	42.96	927	
	Urban	16102590	8481617	7620973	70.62	899	
UJJAIN (Dt.)	Total	1709885	881509	828376	87.87	940	38.74
	Rural	1047558	537543	510015	48.09	949	
	Urban	662327	343966	318361	72.73	926	
BLOCKS							
Khacharod (Average)	*Total*	*356721*	*183032*	*173689*	*44.86*	*951*	*39.35*
	Rural	*216344*	*110321*	*106023*	*39.61*	*961*	
	Urban	*140377*	*72711*	*67666*	*63.78*	*940*	
Mahidpur	Total	217246	11968	105278	31.99	940	16.46%
	Rural	181483	93567	87916	25.57	940	
	Urban	35763	18401	17362	63.87	944	
Ghatiya	Total	118459	60991	57468	39.88	942	00
	Rural	118459	60991	57468	39.88	942	
	Urban	00	00	00	00	000	
Tarana (Below average)	*Total*	*217181*	*111579*	*105602*	*56.80*	*946*	*9.87%*
	Rural	*195726*	*100558*	*95168*	*55.75*	*946*	
	Urban	*21455*	*11021*	*10434*	*66.14*	*947*	
Ujjain (Above average)	*Total*	*563636*	*292483*	*271153*	*67.82*	*927*	*76.40%*
	Rural	*132967*	*68260*	*64707*	*43.27*	*948*	
	Urban	*430669*	*224223*	*206446*	*75.13*	*921*	
Badnagar	Total	236642	121456	115186	79.01	948	14.39%
	Rural	202579	103846	98733	79.06	951	
	Urban	34063	17610	16453	78.73	934	

Source: *Census of India 2001, MP, Provisional Population Totals Rural –Urban Distribution* Paper 2 of 2001, Director of census operations, M.P., pp. 96 - 97,p 106.

District of Sidhi with an urban population of 14.28% has 8 blocks and 9 tehsils. The same selection method followed in the former district was adopted in Sidhi district also. Three blocks, Gopandbanas (Sidhi), having 19.72% urban population, which was closest to district urbanisation percentage, Baidhan with 44.38% urban population, which was above the district urbanisation percentage and Rampur Naikin with 8.57% urban population, which was below the district urbanisation percentage, were selected as the blocks for the study. The block of Rampur Naikin, which was identified as the below average block, was divided into two tehsils, Rampur Nakin and Churhat **(See Table 6).**

Table 6: Blocks in Sidhi District – Some Indicators

State / District/ Block	Total Rural Urban	Population-2001			Female Literacy Rate	Sex Ratio	% of Urban Population
		Persons	Male	Female	2001	2001	2001
MADHYA PRADESH	Total	60385118	31456873	28928245	50.55	920	26.67%
	Rural	44282528	22975256	21307272	42.96	927	
	Urban	16102590	8481617	7620973	70.62	899	
SIDHI (Dt.)	***Total***	1830553	947276	883277	36.43	932	14.28%
	Rural	1569163	806043	763120	32.68	947	
	Urban	261390	141233	120157	59.21	851	
BLOCKS							
Rampur Naikin *(Below average)*	***Total***	***268402***	***138010***	***130392***	***42.09***	***945***	***8.57 %***
	Rural	***245399***	***125814***	***119585***	***41.48***	***952***	
	Urban	***23003***	***12196***	***10807***	***52.00***	***889***	
Gopandbanas (Sidhi) *(Average)*	***Total***	***231518***	***120933***	***110585***	***45.34***	***914***	***19.72 %***
	Rural	***185854***	***96061***	***89793***	***39.02***	***935***	
	Urban	***45664***	***24872***	***20792***	***70.86***	***836***	
Sihawal	Total	216361	110114	106247	38.72	965	00
	Rural	216361	110114	106247	*38.72*	965	
	Urban	00	00	00	*38.72*	000	
Chitrangi	Total	258409	134338	124071	26.04	924	2.76 %
	Rural	251266	130515	120751	24.71	925	
	Urban	7143	3823	320	69.96	868	
Deosar	Total	243817	124946	118871	25.70	951	00
	Rural	243817	124946	118871	25.70	951	
	Urban	00	00	00	00	000	
Majholi	Total	128836	66374	62462	38.54	941	00
	Rural	128836	66374	62462	38.54	941	
	Urban	00	00	00	00	000	
Kusmi	Total	65086	33241	31845	29.32	958	00
	Rural	65086	33241	31845	29.32	958	
	Urban	00	00	00	00	000	
Baidhan *(Above Average)*	***Total***	***418124***	***219320***	***198804***	***38.39***	***906***	***44.38 %***
	Rural	***232544***	***118978***	***113566***	***23.88***	***955***	
	Urban	***185580***	***100342***	***85238***	***56.66***	***849***	

Source: *Census of India 2001, MP, Provisional Population Totals Rural –Urban Distribution* Paper 2 of 2001, M.P, pp. 96- 97, p 106.

Even though during the preparatory fieldwork we approached the concerned offices for the 2001 Census data at the block level we were told that the data were not yet published. Therefore initially we had to depend on the 1991 Census figures. But later we could collect 2001 Census data on the urbanisation percentage for Sidhi district and its blocks from the district collector's office. Subsequently the 2001 Census data was published, which we used for selecting the blocks in Ujjain district during the fieldwork there.

1.5.1.3. Sample Size and Sample Selection

In each selected block all the public providers/institutions like Primary Health Centres (PHC), Community Health Centres (CHCs), Civil hospitals, District hospitals and hospitals of Public Sector Undertakings were mapped. For the purpose of this study a Formal Provider is defined as: one who has been trained in a formal institution which awards a degree or diploma like MBBS, BAMS, BUMS, BHMS, etc , and conduct abortions. Informal Providers are defined as those persons, who do not have recognised qualifications in any of the above mentioned streams, but conduct abortions.

Initially as per the discussions in the Methodology Workshops on 23-24 August 2000, 13-15 December 2000 and 5-6 April 2001, it was decided to cover at least 60 private formal providers/ institutions in each district after mapping. Sixty private providers were considered a sufficient number, in view of the problems in enlisting the participation of private providers for such studies.

None of the PHCs in both the districts were providing abortion service **(See Table 8).** ICMR Task Force Study, had observed in 1991 that majority of the PHCs were lacking in functional equipment and /or trained manpower to carry out pregnancy termination even after two decades of the MTP Act (Jesani A and Iyer A 1993). It appears that even one more decade after the 1991 ICMR task force report also the abortions are not being provided in PHCs in the sample districts. All other public facilities that were providing abortions are included in the sample **(See Table 7).**

Table 7:Participated Facilities by Type and District /Block

S. No.	District/ Blocks	Public		Private		Informal	
		Mapped	Offering Abortion & Consented	Mapped	Consented	Mapped*	Consented
1	**Ujjain**						
1.1	Ujjain *(Above average)*	4	2	32	15	5	5
1.2	Khacharod *(Average)*	5	3	8	8	20	20
1.3	Tarana *(Below average)*	2	1	2	2	50	50
1	**Dist.Total**	**11**	**6**	**42**	**25**	**75**	**75**
2	**Sidhi**						
2.1	Sidhi *(Average)*	5	1	8	8	27	27
2.2	Rampur Nakin *(Below average)*	10	1	4	4	29	29
2.3	Baidhan *(Above average)*	7	3	14	14	39	39
2	**Dist. Total**	**22**	**5**	**26**	**26**	**95**	**95**
	Total	***33***	***11***	***68***	***51***	***170***	***170***

Note **All informal providers have not been mapped*

In the developed district of Ujjain, there were 11 mapped Public facilities, which were supposed, to provide abortion, out of which only 6 were providing the service. In the less developed district of Sidhi, there were 22 identified Public facilities, out of which only 5 were providing the service. Out of 4 PHCs in Ujjain, none were providing abortion services. Of the 15 PHCs in Sidhi too none were giving abortion services. Out of the 4 CHCs in Sidhi 2 were providing the service. All the 3 civil hospitals in Ujjain were providing the service. Both the district hospitals were also providing the service. In addition the hospitals attached to certain public sector undertaking in Ujjain and Sidhi were also providing abortion services. These were the NTPC hospital Singrauly and the Nehru Shatabdhi hospital for the colliery workers of Singrauly both in Sidhi district and an ESI hospital in Ujjain block **(Tables 8)**. Though the NTPC hospital was meant for the workers of the National Thermal Power Corporation, and the Nehru Shatabdhi hospital, was meant for the Colliery workers, we were told that these hospitals treated the local people also for a charge. Abortions were conducted free of charge in these hospitals for the local population who were non-workers, on the condition that tubectomies

would be conducted post abortion. The areas where these hospitals are located are populated mainly by the workers of these plants /mines and they therefore become the natural users of these hospitals.

Table 8: Public Facilities Providing / Not Providing Abortion in the Selected Blocks of Ujjain & Sidhi Districts

Name of Public Facilities	Public Facilities in the three selected blocks of Ujjain		Public Facilities in the three selected blocks of S idhi	
	Total No. of Facilities	No. of providing Facilities	Total No. of Facilities	No. of Providing Facilities
PHC	4	0	15	0
CHC	Nil	NA	4	2
Civil Hospital	3	3	Nil	NA
Maternity Home	2	1	Nil	NA
District Hospital	1	1	1	1
ESI hospital & hospitals attached to the Public Sector Undertakings	1	1	2	2
Total	***11***	***6***	***22***	***5***

Many formal private providers in Ujjain district did not participate in the study. Non participation was particularly high in Ujjain block, which had a high concentration of providers. Therefore only those formal private providers from Ujjain, who were willing to participate in the study, were included in the sample. Though we mapped 42 private facilities providing abortion service, only 25 participated in the study. In Sidhi however, due to the less organised nature of the medical practitioners in an underdeveloped district, all the 26 providers who were mapped have participated in the study. On the whole from the two districts together, 51 out of 68 mapped private providers participated **(See Table 7).**

Initially we had thought of including only five informal providers per block in the sample. But it was found during the mapping that informal providers constituted the major chunk of abortion providers in rural areas and even in some urban areas of both districts. Therefore we included a substantial number of informal providers also in the study. The block wise break up of informal providers is presented in **Table 7.** As against many of the formal providers who refused to

participate in the study, all the mapped informal providers viz- 75 in Ujjain and 95 in Sidhi participated in the study. All together 170 informal providers have participated **(See Table 7).**

Tarana block, which is the least developed among the three blocks in Ujjain district, accounted for 50 out of the 75 informal providers included in the sample from Ujjain. Due to the underdeveloped nature of Sidhi district, the concentration of informal providers was quite high. Even from the above average block of Baidhan, 39 informal providers could be included in the study. Though the block is urbanised above the district average, the large number of migrant coalmine workers in the block from the unorganised sector who do not have proper access to the large hospitals run by the public sector undertakings, would be using the informal providers as a cheaper option **(See Table 7).**

1.5.2. Tools Used

The following tools were used for the data collection. The administration schedule addressed the administrator or the provider in charge of him / her. The provider schedule concerned the providers of abortion service in the facility and were administered to them. Facility assessment data was collected through direct observation by the investigators and from the administrator / provider in charge. The schedule for informal provider addressed the issues of informal provision and was administered to such providers. **(See Table 9).**

Table 9: Data Collection tools used

Instrument	Requirements	No. of forms required	No. of forms actually filled
Administrator Schedule	1 per participating facility	62	62
Provider Schedule	All providers at each facility which actually provides services	89	68
Facility Assessment	1 per facility	62	46
Informal Provider	1 per provider	170	170
FGDs	Nil	Nil	Nil

1.5.3. Data Collection Methods

1.5.3.1. Mapping Method: Process Of Listing

In each selected block the investigators enumerated all formal and institutional abortion providers, including registered and unregistered, public and private providers by using a listing form. This form recorded a few basic characteristics of the facility and the willingness to participate in the study.

For listing the providers, help from the CMOs of both districts, superintendents of district hospitals, nurses, medical representatives, chemists, hospitals, local journalists, and other concerned people were utilised. A detailed map of each district and of selected blocks, which were collected from the concerned Block Development Officers, were also utilised for the purpose.

In Ujjain district, the second most developed district in Madhya Pradesh, the refusal was very high from formal providers particularly in Ujjain block. Some of the doctors accepted that they provided abortion, but refused to give any information, which we presume was because many of them were not having registration. Due to the lack of co-operation on the part of formal private providers in Ujjain district and the large number of informal providers, even though Ujjain was a highly developed and urbanised district, we included 75 informal providers also in the study.

After listing all formal providers in Sidhi district, we found that there were very few in number due to the district being underdeveloped. This led us to include more informal/traditional providers.

Each nook and corner of the selected blocks was explored to list the informal/traditional providers who constituted a major chunk of the abortion service in the district. Detailed maps of the both districts were also utilized for the mapping purpose. Some of the providers who claimed to be BAMS, BHMS, and BUMS were also included in the category of informal providers, since they appeared to be quacks, virtually having no facility, equipment or medicine to treat the patients.

1.5.3.2. Canvassing Various Questionnaires

After a brief meeting with the head of each institute or the provider himself,

the facility was mapped and the consent was sought for the study. As per the appointment given by the respondent, interview was conducted using the standard protocols. A pair of investigators, one with a social science background and the other with a nursing background conducted the interviews. They had to go many times to the same facility to get the appointment, conduct the interview and complete all the protocols. Out of 46 checklists, the nurses, who were members of the investigators team filled 41 by directly observing the OT, the equipment and instruments available in these facilities. The remaining 5 were filled up as per the information orally given by the provider, since these facilities didn't allow the investigators to observe the OT and equipments etc.

The information for all schedules was collected by investigators through direct interviews. Investigators were supervised by the researchers who were also on the field along with them. The researchers have accompanied investigators, conducted more than random checking and made sure that the investigators had interviewed the concerned administrators/ providers. All the forms were checked in the evening of every fieldwork day and gaps or inadequacies in them were corrected with further visits to the facilities/ providers.

1.6. Selection and Training of Investigators

Out of the six investigators in team, three were postgraduates in social work with some field experience. They were helpful in dealing with the doctors and collecting data, which had more social and economic bearing. Two female investigators were nurses with Diploma in General Nursing from Sulthania Ladies hospital, Bhopal. The nurses assisted in collecting data on medico-technical aspects of abortion services, particularly in observing the equipment and instruments and filling up the Checklist.

For local support in the sample districts, two social activists from Bharat Gyan Vigyan Samiti (BGVS), Bhopal one activist with a base in Sidhi and another with a base in Ujjain were included in the investigators team. They were primarily helpful in providing local contacts and in listing formal and informal providers in the district. They were also given training as part of the investigators team.

. Three day residential training was given to the investigators, prior to the fieldwork in each district using common guidelines and instruction manual. A detailed explanation of social, economic, medical, legal and ethical aspects of all the questions was provided during the training. The Project Co-ordinator for MP, explained the social, legal and ethical aspects of abortion, which were also implied in the schedules used for data collection. A Gynaecologist explained the medical and surgical processes and terminologies mentioned in the protocols, particularly the methods of abortion, medicines used for abortion, post abortion complications, various MTP instruments, their usage etc to the investigators. Later the investigators, with the Gynaecologist and the researchers visited a hospital to see for themselves the physical infrastructure, MTP equipment, instruments, amenities and Operation Theatre used for abortion. Here also the gynaecologist demonstrated and explained the functioning of various equipment and instruments. At the end of the training pilot interviews were conducted for each investigating pairs, consisting of an investigator from_social science background and a nurse in Sulthania Ladies Hospital, Bhopal.

This training programme, which was initially conducted for the fieldwork in Sidhi district, was repeated before the fieldwork in Ujjain also. This helped to reinforce and recollect the training given to the team members who conducted fieldwork in Sidhi and also to orient the two new nurses and one male investigator who joined freshly.

1.7. Ethical Concerns

1.7.1. Clearance of Protocols by Ethical Committee

The institutional ethics committee discussed the questionnaires and approved them. Several members foresaw the possible non co-operation or inadequate co-operation from the formal providers and felt that the researchers were unlikely to create ethical problems for respondents. Providers had the power to deny interviews. Copies of the protocols were circulated to the members for their consideration before the discussion.

1.7.2. Participation of ECG Members

No ECG member was involved during the training of the investigation team. One ECG member concerned was not available and the other concerned member had

unexpectedly developed certain urgent personal matters to attend to. Therefore the ethical aspects of the study and orientation in that regard were given to the team members by the project co-ordinator, MP, during the three-day residential training programme before the Sidhi fieldwork and subsequently in another training programme before the fieldwork in Ujjain.

1.7.3. Informed Consent

Six formal providers refused to give written consent but agreed to provide information. Taking in to account their oral consent, the interviews were conducted and the data collected. All the rest gave written consent.

1.7.4. Respondents Decision to Participate

The decision to participate in the study was that of the respondent alone. After a brief meeting with the head of each institute or the provider himself, the facility was mapped and consent sought for the study. As per the appointment given by the respondent, the investigators conducted the interview. The investigator always respected the rights and dignity of the respondent. The respondent had the right to stop the interview in between. While the investigators were collecting information on the Administrator Schedule, one respondent who had given his consent, stopped to co-operate further with the interview. Investigators had to stop the interview at that point, which they did.

1.7.5. Privacy of Interviewees

The interview was conducted either in the private room of the administrator/ provider, or in the consulting room of the provider without the presence of others.

1.7.6. Concealing Identity

In order to hide the identity of the respondents, the names and addresses of the facilities, administrators and providers on the consent form and the schedules were covered with stickers and a numerical code was given to each protocol.

1.7.7. Use of Excess Data

Excess data / information collected during fieldwork needs to be identified and its quantum assessed. The mode of using the excess data is to be decided.

1.7.8. Data Sharing Plans

The final data has been shared with the AAI secretariat and is to be used as per the decision of the AAP-I network.

1.7.9. Ethical Dilemmas

Data collection was done within the ethical framework of social science research. Certain hospitals which were likely to be having qualified / trained abortion providers and the necessary equipment / instruments refused to co-operate with the study. They may have been un-registered. But their inclusion in the sample would have helped to increase the sample size and also build a stronger case for providing adequate training facilities and simplifying the registration process.

II. POLICY AND LEGAL ISSUES

2.1. Certification

Among the 25 providing institutions, which participated from Ujjain district, only 9 that i.e. 36% were certified in terms of the institution. The rest of the 16, i.e. 64% had never tried for registration. In Sidhi district, which is an underdeveloped district, only 2 out of the 26, i.e. 7.7% institutions, which participated, were having either the provider or the site certified. Of the remaining 24, seventy seven percent did not attempt for registration ever. In the case of nearly 12% i.e. 3 institutions, they had tried but their applications were rejected. There was no response in this regard form one institution. On the whole about 22% of institutions had site certification. Of the rest 77% had no site certification. **(See Table 10)**

In the case of the nine certified private institutions the mean number of months taken for obtaining certification was 9 months in Ujjain and 6.7 months in Sidhi. Average number of times registration papers were rejected was 3 times in Ujjain and 1.5 times Sidhi. For the districts together, the mean time gap between application and certification was 7.18 months and the average number of times registration papers were returned for modification was 2.73 times **(See Table 11).**

Twenty four percent of the uncertified facilities in both Ujjain and Sidhi were of the opinion that: registration was not necessary, as they perceived no problem in delivering MTP service. Interestingly 3 facilities in Ujjain 18.7% and 2 (10%) expressed ignorance about MTP registration. Fifteen percent of institutions: (5) in Sidhi mentioned, "registration required more money". Three institutions amounting to 19% in Ujjain were not interested to register. Sixty seven percent out of the 31 institutions, which tried for registration, said that they did not know, why they were refused registration **(See Table 12).**

2.2. Reporting Requirements

Among 11 public facilities all (100%) of them were reporting all MTP cases. At the same time only 6 i.e. (55%) of the 11 certified private facilities were reporting all the cases. The remaining 45% (15)

certified facilities did not report any cases. No private facility mentioned that they were reporting only some cases **(See Table 13).** Reasons for not reporting included responses such a, "reporting is not necessary" and no order issued by CMO or Govt. staff **(See Table 13).**

2.3. Consent

Consent was taken for abortion in the case of 11 Public sector facilities. In the case of the private facilities 92% took consent and the remaining nearly 8% did not take consent. The type of the consent taken was written in all the public institutions, while only 66% of private institutions took written consent. Only oral consent was taken in 34% of private institutions **(See Table 14).**

Though the MTP Act specifies the need for only the women's consent for conducting an abortion, 0% of public institutions conducted abortions with only the women's consent. Only 1 private institution among the 51 i.e. just (2%) of private institutions also did abortion, with only the woman's consent. Woman's and her husband's consent was taken in 100% of public institutions and 96% of private institutions. Around 73% of public institutions conducted abortions with the consent of the woman and any family member or accompanying person. The above responses of providers are not mutually exclusive as they are mentioning the consents of different persons under which they will conduct abortion. All these consents need not be applicable in every case **(See Table 14).**

All public facilities allowed us to see the consent form, while only 45% of private facilities permitted us to do that. Abortion procedure was specified in only 28% of the consent forms used by private hospitals. The corresponding percentage for public hospitals was relatively higher at 64%. Regarding specification on Analgesia/ anaesthesia, only 46% of even public hospitals mentioned it in the consent form, while only 29% of private institutions mentioned it. Eighty two percent of public hospitals and 93% of private institutions had provision for woman's consent in the forms. Sixty four percent of public and 79% of private institutions had provided for witness' signature also on the consent form **(See Table 15).**

Table 10: Certification Status of Private Facilities

Certification Status of Private Institutions	Ujjain (Developed)	Sidhi (Less Developed)	Total
	Private Facilities N = 25 %	Private Facilities N = 26 %	Private Facilities N = 51 %
Facilities with site certification	36.0 % (9)	7.7 % (2)	21.6 % (11)
Never tried for registration	64.0 % (16)	76.9 % (20)	70.6 % (36)
Tried but application was rejected	Nil	11.5 % (3)	5.0 % (3)
No response	Nil	3.8 % (1)	1.9 % (1)
Facilities without certified provider or site certification	64.0% (16)	92.3% (24)	78.4% (40)

Table 11: Difficulties Faced in the Registration Process: Already Certified Facilities

Difficulties faced in Registration Process Private Institutions	Ujjain	Sidhi	Total
	Private certified facilities N = 9	Private certified facilities N = 2	Private certified facilities N = 11
Average time between application and certification (Mean)	9 months	6.7 months	7.18 months
Average No. of times registration Papers were returned for modifications	3 times	1.5 time	2.73
Problems faced in certification			
Lack of information from CMOs Office	Nil	1	1
Application returned for modification	Nil	1	1
Registration is a long procedure	1	1	2
Registration centre is far away	Nil	1	1
Registration requires more money	Nil	1	1
Information not available	Nil	1	1

Table 12: Difficulties faced in the Registration Process: Uncertified Facilities

Number of private facilities who have not applied for registration	Ujjain N = 16 %	Sidhi N = 20 %	Total N = 36 %
Reasons for Facility never trying For Registration			
Long and complicated procedure	Nil	15% (3)	8.3% (3)
Registration facility is not available at District level	Nil	5% (1)	2.7% (1)
Regi. is not necessary since there is no problem in delivering MTP service	25% (4)	25% (5)	25% (9)
Not qualified for registration	12.5% (2)	10% (2)	11.1% (4)
MTP is provided very rarely	Nil	10% (2)	5.5% (2)
Registration require more money	Nil	15% (3)	8.3% (3)

No knowledge about MTP registration	18.7% (3)	10% (2)	13.8% (5)
Will register after DGO course	Nil	5% (1)	2.7% (1)
Prescribed facility for registration is not available in the institution	6.2% (1)	5% (1)	5.5% (2)
Not qualified for registration	6.2% (1)	Nil	2.7% (1)
Not interested	18.7% (3)	Nil	8.3 % (3)
No response	12.5% (2)	5% (1)	8.3% (3)
Reasons for Facility being Refused Registration	**Facilities Refused registration N = 0 %**	**Facilities Refused registration N =4 %**	**Total N = 4 %**
Do not know	Nil	50% (2)	50% (2)
Didn't give more money	Nil	25% (1)	25% (1)
No response	Nil	25% (1)	25% (1)

Table 13: Facilities and their Reporting of MTPs

Reporting MTPs	**Public N =11 %**	**Certified Private Facilities - N = 11 %**	**Total N = 22 %**
Report all MTPs	100% (11)	54.5% (6)	77.2% (17)
Report Some MTPs	Nil	Nil	Nil
Do not Report Any MTPs	Nil	45.5% (5)	22.8% (5)
Reasons for not reporting	**Public facilities who do not report. N = 0 %**	**Certified Private Facilities who do not report. N = 5 %**	**Total N = 5 %**
Reporting is not necessary	Nil	20% (2)	40% (2)
No order from the CMO or Govt. staff	Nil	40% (2)	40% (2)
Information not available	Nil	20% (1)	20% (1)

Table 14: Consent Requirements at Public and Private Sector Facilities

Consent Requirement	**Public - N = 11 %**	**Private - N = 51 %**	**Total - N = 62 %**
Consent Taken	100% (11)	92.1% (47)	93.5% (58)
Consent not taken	Nil	7.8% (4)	6.4% (4)
Type of Consent Taken	**Public N = 11 %**	**Private N = 47 %**	**Total N = 58 %**
Written	100.0% (11)	65.9 % (31)	72.4% (42)
Oral	Nil	34.0 % (16)	27.5% (16)
Person whose consent is taken before abortion *			
Woman alone	Nil	2.1% (1)	1.7% (1)
Woman + any family member	72.7% (8)	76.5% (36)	75.8% (44)

/accompanying person			
Woman +husband	100.0% (11)	95.7% (45)	96.0% (56)
Husband or other family members but NOT the woman herself	Nil	Nil	Nil
Whether allowed to see consent form or not	**Public with written consent N = 11 %**	**Private with written consent N = 31 %**	**Total N = 42 %**
Yes	100.0% (11)	45.1% (14)	59.5% (25)
No	Nil	53.1%(17)	40.5% (17)

*It is derived based on the yes responses to the different options given.

Table 15: Observation of Consent Form

Total Number of institutions where Consent Forms were observed	**Public N = 11 %**	**Private N =14 %**	**Total N = 25 %**
Consent Form contains following			
Specification of Abortion Procedure	63.6% (7)	28% (4)	44.0% (11)
Specification of analgesia/ anaesthesia	45.5% (5)	28.6% (4)	36.0% (9)
Provision for woman's consent	81.8% (9)	92.9% (13)	88.0% (22)
Provision for others consent	81.8% (9)	50.0% (7)	64.0% (16)
Provision for witness signature	63.6% (7)	78.6% (11)	72.0% (18)

III. Facility, Infrastructure, Human power and Equipment

3.1. Infrastructure

The physical facilities such as, Operation Theatre, MTP instruments, sterilisation process, telephone, cleanliness etc available in abortion providing institutions is given below. Out of the 62 institutions 46 facilities i.e. 74.19% allowed to fill up the Checklist. Among them 41 i.e. 89.1% institutions allowed us to directly observe the facilities to fill up the protocol.

Among the private facilities 79% of the not certified facilities and 100% certified private facilities had waiting area with seating arrangements, while out of two CHCs 50% and 100% of District, civil hospitals and other public institutions had this facility. Fifty percent of CHCs and 78% of District/ civil hospitals and other public facilities had more than one toilet, while 82% of certified private facilities too had more than one toilet. On the other hand only 33% of the not certified private facilities had more than one toilet. Six out of 24 not certified private facilities i.e. 25% of them were not having toilets. These could be the clinics of individual providers where also abortions are done. Hundred percent of CHCs as well as certified private facilities and 89% of District/ civil hospitals and other public and 71% of uncertified private facilities had water availability in the toilets **(See Table 16).**

Visual privacy and auditory privacy in the consulting room of CHCs were 100% and 50% respectively. Eighty nine percent of other public facilities had visual and auditory privacy in the consulting room, while it was 100% among certified private facilities. In the case of uncertified private facilities the percentage for the two variables was relatively less than the other two categories of hospitals i.e. 67% and 50% respectively. In the fifty percent and 89% of CHCs and District/ civil hospitals and other public facilities respectively had beds in the recovery room. In the case of certified and uncertified private facilities 91% and 83% respectively were having beds in recovery room **(See Table 16).**

Fifty percent of CHCs had shadow less OT lamp while none of them had

adjustable focus lamp. Eighty nine percent of District/ civil hospitals and other public facilities and ninety one percent of certified private facilities had adjustable focus lamp. Compared to these two categories only 50% of the uncertified private facilities had adjustable focus lamp. Shadow less OT lamp was available in 67% of District/ civil hospitals and other public facilities and 73% of certified private facilities while in only 21% of uncertified private facilities were having it **(See Table 16).**

3.1.1. Place in Hospitals where MTP was done

Table 16 A, is a continuation of Table 16, and gives information on the place / room in the hospitals where MTP was done. Fifty percent of CHCs used Operation theatre for MTP, while the other 50% used labour rooms. Around seventy eight percent of other public facilities and 64% certified private facilities also used the OT. The percentage of uncertified private facilities, which used OT for MTP was extremely low at 23%. Nine percent of certified private facilities and 5% of not certified private facilities did abortion in separate Gynaec /MTP OT. Twenty three percent of district/ civil and other public facilities also conducted abortions in Gyaec /MTP OT. Among the District, civil and other public facilities, which are supposed to have relatively better facilities also 11% conducted abortions in the out patient department. Twenty three percent of uncertified private facilities also conducted abortions in their consulting room using a curtain to cover. In addition the question of privacy it is a matter of concern as to how the requirements of equipment, instruments could be met when abortion were conducted in OPD and consulting room. **(See Table 16-A).**

3.2. Equipment and Supplies

3.2.1. Observation:

In all the 11 public facilities i.e. (100%) of them, it was possible to observe the Checklist to record the presence of equipment and supplies. On the other hand the corresponding percentage was relatively less at 82% for certified and 88% for non certified private facilities. At the same time it needs to be pointed out that this percentage is still high considering the other states where the same study was conducted. Social Work postgraduates and nurses, who went in pairs, conducted the data collection. The doctors and managements probably did not

perceive any threat from those young investigators. Investigators spoke fluent Hindi also, though a few of them were from Maharashtra. Researchers only monitored their activities and remained in the background, lest they could be seen as a threat by the hospital managements and doctors. **(See Table 17)**

In the following table 18 the basic equipment available in the facilities are mentioned. Sixty seven percent of District/Civil/other public hospitals and certified private facilities had electric suction machine (ESM), whereas only 33% of not certified private facilities had ESM. Eighty nine percent of other public hospitals and 67% of certified private hospitals had MVA syringe. Only 78% of district, civil and other public hospitals and 67% of certified private facilities had at least 3 different sizes of MVA cannulae. The availability of MVA syringe cannulae and adapters among the uncertified private facilities were 67%, 67% and 56% respectively. Among the CHCs only 50% had the above mentioned equipment **(See Table 18)**.

Hundred percent of certified private facilities and CHCs had Sim's/ Cusco's speculum, Tenaculum/ Volsellum, Ovum forceps and Uterine curette. The availability of these instruments among the District / Civil hospitals and other public facilities and certified as well as uncertified private hospitals were on the higher side above 85%. Dilator set was available for 50% of CHCs and 78% of District, civil and other public hospitals while 67% of certified private facilities had the set. Compared to other categories 91% of uncertified private facilities had complete set of Dilators. For further details **(See Table18).**

A higher percentage of public hospitals above the level of CHC and the certified private hospitals were having most of the anaesthesia related equipment. Of the two CHCs in the sample, one did not have either an Oxygen cylinder or a Boyle's Apparatus. Both however had Laryngoscope. At the same time among the District, Civil and other pubic hospitals 89% had Oxygen cylinders, while 78% had Boyle's apparatus and Laryngoscope. Among the certified private facilities 100% had Oxygen cylinders, 89% had Boyle's apparatus and laryngoscope. It is to be noted that not even half of the 21 non certified private facilities, which constituted the large group among the

facilities had either Oxygen cylinders, Boyle's apparatus or Laryngoscope. The actual percentages in the case of each of these is still lower than 50% the case of Boyle's apparatus only one third of them had it. **See Table 19** for details.

Among the sterilisation equipment the two CHCs had steam sterilisers and Formalin Chambers, but only one of them had an autoclave. In comparison to them, 89% of Dist/ Civil and other public hospitals had autoclaves, 100% had steam sterilisers, while only 55% of them had formalin chambers. Among the certified private institutions 100% had autoclaves and 89% had steam sterilisers, while among them also only 44% had formalin chambers. The availability of all these equipment was also lower among the non-certified providers. Only 62% had autoclaves and 76% had steam sterilisers while only 29% had formalin chamber **(See Table 20).**

In the case of sterilisation related consumables, a higher level of availability was found in public hospitals as well as the certified and non-certified private facilities. A lower level of availability was seen only in the cases of Glutaraldehyde in public hospitals and non-certified private institutions **(See Table 20).**

Among the drugs used for inducing abortion or cervical priming, Ethcrydine was available in only up to or less than 50% hospitals in the four categories of hospitals. Its availability was the lowest at 29% in private non-certified hospitals and highest in the CHCs at 50%. (However there were only 2 CHCs in the sample). Prostaglandin was not available at the two CHCs. In the Dist/ Civil and other other public hospitals, Prostaglandin injection was available at 78% institutions. Its availability was also available in an equal number of certified private institutions. At the same time its availability dropped to only 43% in non-certified private institutions. Only (44%) of even Dist/ Civil and other public hospitals had prostaglandin gel. It was still less at 33% in the case of non-certified private institutions. In certified private institutions however 89% had it. In the case of Oxytocin injection except among the CHCs, which had only (50%) availability, the other three categories Viz. Dist/SD/Other public hospitals and the private institutions had a higher availability ranging from (89%) to (100%)

(See Table 21). Among the supporting drugs, IV fluids were available in 91% of non-certified facilities, and 100% each in the other three categories. Analgesics also had a high availability, from 89% in Dist/SD/Other public hospitals to 100% in the other 3 categories.

Among the Family Planning devices, oral pills and, condoms were available in both the CHCs in the sample. Condoms were available in all Dist/SD/Other public hospitals also, while oral pills were available only in (89%) of them. Interestingly the same pattern was seen in certified private institutions also. The non certified institutions showed a slightly low availability of both **(See Table 21).** Again 89% of Dist/SD/Other public hospitals and certified private institutions had IUD. It was slightly less among non-certified institutions and still less at 50% of among CHCs. There was a relatively high availability of injectables only in Dist/ Civil and Other public hospitals and certified private hospitals **(See Table 21).**

Only 10% of the institutions had taken maintenance contracts to repair their abortion related equipment. This percentage was highest among the district/civil/and other public hospitals with 33% and lowest among the CHCs 0% and the uncertified private providers 5%. However one of the two CHCs (50%) did say that they would replace the concerned equipment. The percentage for reported replacement is also low among the District, civil, maternity and other public hospitals 11% and among the certified 0% and uncertified 7.5%. Sixty four percent of certified private institutions, 33% of non-certified private institutions and 22% of district hospitals, civil and other public sector hospitals were getting their equipment repaired in the same towns. Twenty nine percent of institutions had to rely on other cities for getting the equipment repaired **(See Table 22).**

The mean days of time lag due to repairs was reported in certified private and uncertified providers to be 3.90 days and 5.35 days respectively. Power failure/power cuts and equipment breakdown were reported as the two main reasons for postponing abortion provision by the institutes. Among the District/Civil and other public hospitals, 33% institutes had to postpone the service due to equipment disorder and 22% each due to unsterilised instruments and power problems. In a quarter of the uncertified

private hospitals, equipment disorder had caused the delay; while in case of 28% of them power failure was the reason for postponement **(See Table 22)**

3.3. Human Power

There were reportedly one or more full time Gynaecologist (MD/DGO) available at 73% of the public institutions and 45% of certified private institutions. Only 15% of uncertified institutions had a full time gynaecologist. One or more Gynaecologists attended on specific days at 9% of certified private institutions and 13% of uncertified institutions. Thirty Six percent of public institutes and 45% of certified private facilities had one or more full time MBBS doctors. Whereas only 18% of uncertified private institutions had full time MBBS doctors **(See Table 23)**

As high as 81% of institutes did not have an anaesthetist either as full time, on call or attending on certain days. As many as 90% of non certified private institutes did not have any anaesthetist. It appeared therefore that the surgeon themselves were performing the tasks of anaesthetists also. Among the public institutions 36% had full time anaesthetist. On the contrary only 9% of certified private institutions had full time anaesthetists. None of the non-certified institutions had full time anaesthetist. Of the certified private institutes, 21% had anaesthetist on call, while only 10% of non-certified institutes had anaesthetists even on a call basis **(See Table 24).**

There were no nurses in 22% of the institutions. This was mainly accounted for by a bunch of institutes which, belonged to the non-certified segment. As can be seen from table 20, as high as 35% of these institutes did not have any nurses. There were at least 91% of nurses, registered with the nursing council in the public institutions and in 64% of certified private institutions. Only 27% of non-certified institutions were having at least one nurse registered with the nursing council. In 30% of non-certified institutions, there were only nurses trained in-house. Only 20% of such institutions had diploma nurses. On the other hand 72% of public institutions and 45% of certified private institutions had diploma nurses. A lesser percentage of them had nursing degree holders also i.e. 27% and 18% respectively, while only (5%) of non-certified institutes had B. Sc Nurses **(See Table 25).**

Only one public facility and one certified private institute had Social Worker or Counsellor. This points to a lack of understanding of the social skills involved in pre and post abortion counselling **(See Table 25).**

3.4. Provider Characteristics

All together there were 19 Public Providers and 52 Private Providers i.e. 27% and 73% respectively. In the developed district of Ujjain 70% of the providers in the sample were private providers. The pattern was the same in the less developed district of Sidhi also with 76% private providers **(See Table 26).** Among the providers only 34% had qualifications such as MD/MS/DNB in Gynaecology and Obstetrics or had DGOs. Their percentage was 43% in Ujjain and only 24% in Sidhi. Trained providers with MBBS or post graduation in other branches were also only 15.5% all together. They were 19% in Ujjain and 12% in Sidhi. A small 9.86% of providers from ISM and Homeopathy also claimed that they had received training. The question remains as to how they got training in conducting abortions, when the training is supposed to be meant for allopaths with at least an MBBS degree.

The providers in the MP sample have had an average experience of 13 years. It was slightly higher at 14 years in Ujjain and around 12 years in Sidhi district **(See Table 26).**

In terms of gender there were 36 female providers as against 35 males. This slightly more than equal number of female providers was mainly due to a large number of women providers from Ujjain, which is a major urban centre in MP. Out of the 37 providers who participated in the study in Ujjain, 24 were females. On the other hand out of the 34 providers who participated from Sidhi, there were only 12 females. The higher number of participating lady doctors could be due to a higher overall number of lady abortion providers in developed district such as Ujjain **(See Table 26).**

The mean age of providers in the sample was around 41.5 years with very slight variations for the two districts. The range in age varied from 24–65 years, which was also reflected in the districts with only minor differences **(See Table 26).**

Among the 17 providers who had formal training in abortion from the public

sector 77% were either MD/ MS in Gyn, DGO or DNB in Ob- Gyn. One abortion provider in public sector also has learnt doing abortions through informal channels.

In the private sector, out of the 25 providers who had formal training, 11 were either MD/ MS in Ob-Gyn or DGO or DND in Gyn. Twenty four percent had their training in the medical colleges, while 20% had training in District hospitals. Another 12% were trained in other Private / NGO institutions. Surprisingly 80% of those who learnt performing abortion informally, claimed that they had leant it at the medical colleges. The remaining 8% of them said that they learnt from District Hospitals, while another 8% learnt from Private / NGO institutions and a 4% by working with colleagues **(See Table 27)**

According to Table 27, 18 doctors had undergone formal training in MTP excluding MD/ MS/ DNB/ in Ob – Gyn and DGOs. Information was collected on their confidence and whether they currently used the method in which they were trained.

Among the 18 formally trained providers 56% were trained in MVA and 50% told that they were confident of using the method. But only 39% were currently using it. Sixty seven percent got training in EVA, all of them claimed to be confident. However, only 61% were currently using the method. Seventy eight and 72% of formally trained providers got training in D&C and D&E respectively. All of them were confident in using the methods and except a few who were not using D&E, all others were using the methods currently. Training in Extra amniotic and Intra Amniotic methods were acquired by only 39% and 28% respectively and the percentage of providers who practised them were considerably low i.e. 17% and 6% respectively **(See Table 28)**.

More providers from the public sector compared to their counterparts in private sector had training in support areas of abortion provision, such as counselling, universal precautions and reproductive health. In counselling and interpersonal communication 47% of public providers had undergone training, while only 21% of private providers had also undergone. The difference in the percentage of providers

who had undergone training is also marked in the case of reproductive health and rights with 53% trained in the public sector and 33% in the private sector **(See Table 29)**

The various aspects of Quality of Abortion Services, which will constitute a Quality Index of the facilities studied, are presented in **Appendix. II**

Table 16: Proportion of Facilities with listed Physical Facilities

Physical Facilities	Public		Private		Total
	CHC N = 2 %	Dist/ other Hospitals N = 9 %	Certified N = 11 %	Not Certified N = 24 %	N = 46 %
Client privacy and comfort					
Waiting area with seating arrangement present	50.0% (1)	100.0% (9)	100.0% (11)	79.0% (19)	86.9% (40)
Waiting area is sheltered /protected from rain or sun	50.0% (1)	100.0% (9)	100.0% (11)	75.0% (18)	84.8% (39)
Toilet(s) present					
One Toilet	50.0% (1)	22.2% (2)	18.2% (2)	41.7% (10)	32.6% (15)
More than One Toilets	50.0% (1)	77.8% (7)	82.0% (9)	33.3% (8)	54.3% (25)
Toilets have water facility	100.0% (2)	88.9% (8)	100.0% (11)	70.8% (17)	82.6% (38)
Existing toilets appear clean	50.0% (1)	66.7% (6)	90.9% (10)	66.7% (16)	72.0% (33)
Arrangement of visual privacy in consulting room present	100.0% (2)	88.9% (8)	100.0% (11)	67.0% (16)	80.4% (37)
Arrangement for auditory privacy in consulting room	50.0% (1)	88.9% (8)	100.0% (11)	50.0% (12)	69.6% (32)
Arrangement for privacy in recovery room present	100.0% (1)	88.9% (8)	91.0% (10)	54.2% (13)	71.7% (33)
Beds available in recovery room for MTP client	50.0% (1)	89.0% (8)	91.0% (10)	83.3% (20)	85.0% (39)
Condition of procedure room					
Room dust free	50.0% (1)	88.9% (8)	100.0% (11)	79.2% (19)	84.8% (39)
Floor is clean	50.0% (1)	88.9% (8)	100.0% (11)	79.2% (19)	84.8% (39)
Operation table in good condition	50.0% (1)	88.9% (8)	100.0% (11)	70.8% (17)	80% (37)
Recovery room					
Indoor ward	100.0% (2)	55.0% (5)	64.0% (7)	42.0% (10)	52.2% (24)
Other room		44.4% (4)	36.4% (4)	58.3% (14)	47.8% (22)
Additional Sources of Light in procedure room					
Bulb/ tube light	100.0% (2)	100% (9)	100.0% (11)	100% (24)	100.0% (46)
Adjustable focus lamp	Nil	88.9% (8)	91.0% (10)	50.0% (12)	65.0% (30)
Torch	Nil	88.9% (8)	64.0% (7)	29.2% (7)	47.8% (22)
Shadow less OT lamp	50.0% (1)	66.7% (6)	73.0% (8)	21.0% (5)	43.0% (20)
Water supply in procedure room					

Running water available	50.0% (1)	55.0% (5)	36.4% (4)	75.0% (18)	61.0% (28)
Stored water available	50.0% (1)	44.0% (4)	64.0% (7)	21.0% (5)	36.9% (17)
Inadequate water supply	Nil	Nil	Nil	04.2% (1)	2.2% (1)
Electricity & telephone					
Electric connections in working condition	100.0% (2)	88.9% (8)	90.9% (10)	96.0% (23)	93.5% (43)
Telephone facility present	100.0% (2)	66.7% (6)	100.0% (11)	62.5% (15)	74.0% (34)
Communication material	50.0% (1)	66.7% (6)	45.5% (5)	8.3% (2)	30.0% (14)

Table 16.A: Place in Hospitals where MTP was done

Clinical /Technical ** (Room used for MTPs)	Public		Private		Total
	CHC N = 2 %	Dist & other Hospitals N = 9 %	Certified N = 11 %	Uncertified N = 40 %	N = 62 %
Operation theatre	50.0% (1)	77.8% (7)	63.6% (7)	22.5% (9)	38.7% (24)
Gynae/MTP OT	Nil	22.2% (2)	9.1% (1)	5.0% (2)	8.1% (5)
Labour room	50.0% (1)	33.3% (3)	18.2% (2)	12.5% (5)	17.7% (11)
Procedure room	Nil	11.1% (1)	18.2% (2)	27.5% (11)	22.6% (14)
OPD	Nil	11.1% (1)	9.1% (1)	5.0% (2)	6.4% (54)
In consulting room using a curtain	Nil	Nil	Nil	22.5% (9)	14.2% (9)

**Percentage is based on the responses and not on the providers

Table 17: Facilities where Actual Observation of Equipment and Supplies was Possible

Total Number of Checklist	Public	Private		Total
	N = 11 %	Certified N = 11 %	Not Certified N = 24 %	N = 46 %
Observation possible	100.0% (11)	81.8% (9)	87.5% (21)	89.0% (41)
Checklist filled by investigator based on the information given by provider	Nil	18.2% (2)	12.5% (3)	11.0% (5)
Checklist filled by provider (no observation)	Nil	Nil	Nil	Nil

Table 18: Availability of Basic Equipment for Abortion Procedure

Basic Equipment	Public		Private		Total
	CHC N = 2 %	Dist& other hospitals N = 9 %	Certified N = 9 %	Non Certified N = 21 %	N = 41* %
Electric suction machine	50.0% (1)	66.7% (6)	66.7% (7)	33.3% (7)	48.8% (20)
MVA syringe	50.0% (1)	88.9% (8)	67.0% (6)	62.0% (13)	68.3% (28)
MVA cannulae (at least 3 different sizes)	50.0% (1)	78.0% (7)	67.0% (6)	57.0% (12)	63.0% (26)
Adapters for MVA syringe	50.0% (1)	67.0% (6)	55.6% (5)	48.0% (10)	54.0% (22)
Sim's /Cusco's speculum	100.0% (2)	89.0% (8)	100.0% (9)	100.0% (21)	97.6% (40)

Tenaculum/ volsellum	100.0% (2)	89.0% (8)	100.0% (9)	90.5% (19)	93.0% (38)
Vaginal wall retractor	50.0% (1)	78.0% (7)	100.0% (9)	81.0% (17)	82.9% (34)
Ovum forceps	100.0% (2)	89.0% (8)	100.0% (9)	90.5% (19)	93.0% (38)
Uterine curette	100.0% (2)	100.0% (9)	100.0% (9)	90.5% (19)	95.1% (39)
Dilator set (12 sizes)	50.0% (1)	78.0% (7)	67.0% (6)	90.5% (19)	83.0% (33)
Ultrasound available	Nil	44.0% (4)	66.7% (6)	9.5% (2)	29.0% (12)
Complete set for MVA	50.0% (1)	67.0% (6)	55.6% (5)	33.0% (7)	46.0% (19)
Complete set for EVA	50.0% (1)	66.0% (6)	78.0% (7)	28.6% (6)	49.0% (20)
Complete set for D&C	50.0% (1)	78.0% (7)	100.0% (9)	71.4% (15)	78.0% (32)

*Facilities where actual observation was possible]

Table 19: Availability of Anaesthesia Related Equipment

Anesthesia Related equipment	Public		Private		Total
	CHC N = 2 %	Dist / Other Hospitals - N = 9 %	Certified N = 9 . %	Not certified N = 21 %	N = 41 %
Oxygen Cylinder	50.0% (1)	89.0% (8)	100.0% (9)	43.0% 9)	66.0% (27)
Boyle's Apparatus	50.0% (1)	78.0% (7)	89.0% (8)	33.0% (7)	56.0% (23)
Laryngoscope	Nil	78.0% (7)	100.0% (9)	38.1% (8)	58.0% (24)

Table 20; Availability of Sterilization /Infection Prevention Equipment and Consumables

Sterilisation Equipment	Public		Private		Total
	CHC N = 2 %	Dist & Other hospitals N = 9 %	Certified N = 9 %	Non certified N = 21 %	N = 41 %
Autoclave drum	50.0% (1)	89.0% (8)	100.0% (9)	62.0% (13)	76.0% (31)
Steam sterilizer	100.0% (2)	100.0% (9)	89.0% (8)	76.2% (16)	85.0% (35)
Formalin chamber	Nil	55.0% (5)	44.0% (4)	28.6% (6)	36.6% (15)
Sterilisation related Consumables					
Savlon	100.0% (2)	100.0% (9)	100.0% (9)	100.0% 21)	100.0% (41)
Povidoneiodine	100.0% (2)	89.0% (8)	100.0% (9)	85.7% (18)	90.0% (37)
Glutaraldehyde	50.0% (1)	66.7% (6)	100.0% (9)	61.9% (13)	70.7% (29)
Bleaching powder	100.0% (2)	88.9% (8)	89.0% (8)	95.2% (20)	92.7% (38)
Long rubber gloves	50.0% (1)	88.9% (8)	89.0% (8)	100.0% 21)	95.1% (39)

Table 21: Availability of Drugs and Other Consumables

Drugs used for inducing Abortion or cervical priming	Public		Private		Total
	CHC N = 2 %	Dist / Other Hospitals N = 9 %	Certified N = 9 %	Non Certified N = 21 %	N = 41 %
Ethcrydine	50.0% (1)	44.0% (4)	44.0% (4)	28.6% (6)	36.6% (15)
Prosataglandin (carboprost inj)	Nil	78.0% (7)	78.0% (7)	42.9% (9)	56.1% (23)
Prostaglandin gel	Nil	44.0% (4)	89.0% (8)	33.3% (7)	46.0% (19)

Oxytocin injection	50.0% (1)	89.0% (8)	100.0% (9)	95.2% (20)	92.7% (38)
Supporting Drugs					
IV fluids	100.0% (2)	100.0% (9)	100.0% (9)	90.5% (19)	95.0% (39)
Analgesics	100.0% (2)	89.0% (8)	100.0% (9)	100% (21)	97.6% (40)
Contraceptives					
Oral pills	100.0% (2)	89.0% (8)	88.9% (8)	81.0% (17)	85.0% (35)
Condoms	100.0% 2)	100.0% (9)	100.0% (9)	71.4% (15)	85.4% (35)
Injectables	50.0% (1)	87.5% (7)	66.7%(6)	28.6% (6)	58.8% (20)
IUDs	50.0% (1)	89.0% (8)	89.0% (8)	81.0% (17)	83.0% (34)

Table 22: Maintenance of Equipment

Arrangements for Equipment Repair	**Public**		**Private**		**Total**
	CHC N = 2 %	**Dist/ Other Hospitals N = 9 %**	**Certified N = 11 %**	**Not Certified N = 40 %**	**N = 62 %**
Sent to dealer in same town	Nil	22.0% (2)	64.0% (7)	32.5% 13)	35.5% (22)
Sent to another city	50.0% (1)	33.0% (3)	27.3% (3)	27.5% 11)	29.0% (18)
Covered by maintenance contract	Nil	33.0% (3)	9.1% (1)	5.0% (2)	9.7% (6)
Other- Replace	50.0% (1)	11.0% (1)	Nil	7.5% (3)	8.1% (5)
Time lag between breakdown and repair *(Mean & Range)*	11 days *(7-15)*	37.22 days *(3-180)*	3.90 Days *(2-9)*	5.35 days *(2-28)*	11. 04 days *(2 -180)*
Not applicable **	Nil	Nil	Nil	27.5% (11)	17.7% (11)
Facilities that have had to postpone service provision for maintenance reasons					
Equipment out of order	Nil	33.0% (3)	Nil	25.0% (10)	21.0% (13)
Instruments not sterilised	Nil	22.0% (2)	Nil	7.5% (3)	8.0% (5)
No electricity	Nil	22.0% (2)	18.2% 2)	27.5% (11)	24.2% (15)
No water	Nil	Nil	Nil	5.0% (2)	3.2% (2)

** These facilities do not have instruments since they are providing only medically induced abortions and they are non- allopaths such as homeopathic and Ayurvedic.

Table 23: Availability of Abortion Service Providers at Different facilities

Number of Service Providers	**Public**	**Private**		**Total**
	N = 11 %	**Certified N = 11 %**	**Not Certified N = 40 %**	**N = 62 %**
Gynaecologist (MD / MS/ DGO)				
One or more Full time (on staff)	73.0% (8)	45.0% (5)	15.0% (6)	31.0% (19)
One or more available on call	Nil	Nil	Nil	Nil
One or more who attend on specific days	Nil	9.0% (1)	12.5% (5)	10.0% (6)
MBBS				
One or more Full time (on staff)	36.0% (4)	45.0% (5)	17.5% (7)	26.0% (16)
One or more available on call	Nil	Nil	Nil	Nil

One or more who attend on specific days	Nil	18.0% (2)	Nil	3.0% (2)
Others total				
One or more Full time (on staff)	18.0% (2)	27.0% (3)	62.5% (25)	48.0% (30)
One or more available on call	Nil	Nil	Nil	Nil
One or more who attend on specific days	Nil	Nil	7.5% (3)	5.0% (3)

Table 24: Availability of Anaesthetist (MD or diploma) at Different Facilities

Anaesthetist (MD or Diploma)	Public	Private		Total
	N = 11 %	Certified N = 11 %	Non certified N = 40 %	N = 62 %
Full time (on staff)	36.0% (4)	9.0% (1)	NA	8.0% (5)
Available on call	NA	18.0% (2)	10.0% (4)	10.0% (6)
Attends on some days	NA	NA	NA	NA
Anaesthetist (MBBS)				
Full time (on staff)	NA	NA	NA	NA
Available on call	NA	9.0% (1)	NA	2.0% (1)
Attends on some days	NA	NA	NA	NA
Other arrangements	NA		NA	NA
NO Anaesthetist	64.0% (7)	64.0% (7)	90.0% (36)	81.0% (50)

Table 25: Availability of Nursing and Support Staff at Different Facilities

Availability of Nursing Staff	Public	Private		Total
	N = 11 %	Certified N = 11 %	Non Certified N = 40 %	N = 62 %
At least one degree qualified nurse available	27.0% (3)	18.0% (2)	5.0% (2)	11.0% (7)
At least one diploma trained nurse available	72.0% (8)	45.0% (5)	20.0% (8)	34.0% (21)
One or more ANM /s	45.0% (5)	36.0% (4)	10.0% (4)	20.0% (13)
Only In house trained nurse	NA	18.0% (2)	35.0% (14)	26.0% (16)
No nurses	NA	NA	35.0% (14)	22.0% (14)
At least one nurse registered with nursing council	91.0% (10)	64.0% (7)	27.0% (11)	45.0% (28)
Social Worker / Counsellor	9.0% (1)	9.0% (1)	Nil	3.0% (2)

Table 26: Profile of Interviewed Abortion Providers

Profile of Interviewed	Ujjain N = 37	Sidhi N 34	Total N 71
Sector in which practicing			
Private	26	26	52
Public	11	8	19
Both	Nil	Nil	Nil

Training			
MD/DGO /MS/DNB in Ob/gyan	16	8	24
Others with formal training in MTP procedures			
MBBS	6	2	8
MS/MD in other branch	1	2	3
Other			
Trained in ISMs	5	1	6
BHMS	1	Nil	1
Without formal training in MTP procedures			
MBBS	Nil	5	5
MS/MD in other branch	Nil	2	2
Trained in ISMs	3	9	12
Other			
BHMS	3	4	7
Years of providing abortion services (Mean & range)	13.72 (1-30)	12.08 (1-30)	12.94 (1-30)
SEX			
Female	24	12	36
Male	13	22	35
Age (Mean Age in years & Range)	42.15 (24 - 62)	40.82 (26 - 65)	41.52 (24 - 65)
Information not available *	2	1	3

(* One provider from district Sidhi terminated the interview in between and non of the providers from the other two facilities of the Ujjain district were available for interview)

Table 27: Place of Training

Place of training	Public		Private	
	Formal training N = 17 %	Informally learnt N = 1 %	Formal training N = 25 %	Informally learnt N = 25 %
Teaching/ medical college	5.9% (1)	100.0% (1)	24.0% (6)	80.0% (20)
District hospital	17.6% (3)	NA	20.0% (5)	8.0% (2)
Private hospital	NA	NA	12.0% (3)	8.0%(2)
By working with a colleague	NA	NA	NA	4.0% (1)
Not applicable /DGO/MD /MS/DNB in Ob-gyn.	76.5% (13)	NA	44.0% (11)	NA
Information not available	1		2	

Table 28: Types of Procedures Trained in

Types of Procedures Trained	Trained N** = 18 %	Feel confident N = 18 %	Actually Providing N = 18 %
MVA	55.5% (10)	50.0% (9)	38.9% (7)
EVA	66.7% (12)	66.7% (12)	61.1% (11)
D&C	77.8% (14)	77.8% (14)	77.8% (14)
D&E	72.2% (13)	72.2% (13)	61.1% (11)
Extra amniotic method	38.9% (7)	16.7% (3)	16.7% (3)
Intra amniotic method	27.8% (5)	11.1% (2)	5.5% (1)

**Note: the N in this table is derived from the total Number of providers who have undergone formal MTP training. Others like 24 - DGO/MD/MS in Ob. Gyn. and 26- informally trained providers are excluded. Information is not available for 3 providers.

Table 29: Providers who have Received Training in Support Areas

Trained in support areas	Public N = 19 %	Private N = 52 %	All N = 71 %
Counselling and Inter Personal Communication	47.4% (9)	21.1% (11)	28.2% (20)
Universal precautions	21.0% (4)	15.4% (8)	16.9% (12)
Reproductive health and rights	52.6% (10)	32.7% (17)	38.0% (27)
Information not available	5.3% (1)	3.8% (2)	4.2% (3)

IV. Constellation of Available Services and Their Performance

None of the PHCs in the developed district of Ujjain or the less developed district of Sidhi were providing abortion. Of the 4 CHCs in Sidhi district also only two were providing. However, all the 6 public hospitals in Ujjain, which belonged to the category of Civil Hospitals/District Hospitals and Public Sector Hospitals, were delivering abortion services. All the three institutions in this category in Sidhi district also were rendering the service. In Ujjain there were only 9 certified institutions for abortion, while the number of certified institutions in Sidhi was only two **(See Table 30)**

Of the two CHCs one is reported as doing abortion up to 12 weeks the other was doing abortions for up to 20 week old pregnancies also. Among the 9 District, Civil and other public hospitals, 56% were conducting abortions for pregnancies up to 12 weeks, while 44% were conducting abortions for up to 20 week old pregnancies. Most of the 11 certified private providers (73%) were conducting abortions up to 12 weeks. The remaining 27% of them were conducting abortions for up to 20 week pregnancies. Vast majority of the 85% non certified private institutions were providing abortion up to 12 weeks. Five percent of them were providing for up to 20 week pregnancies, 8% were providing abortion service for above 20 week old pregnancies also **(See Table 31).**

In the two sample districts of Ujjain and Sidhi as well as in the overall sample, 77% of facilities were conducting abortions of up to 12 week old pregnancies only. Twentythree percent of institutions in the developed district of Ujjain conducted abortions of up to 20 week pregnancies. The corresponding percentage for the less developed Sidhi district was as low as 6. However 13 % ie, 4 institutions in Sidhi district were conducting abortions of above 20 week pregnancies also, which are not legally approved. Three of these institutions were non registered facilities, while one happened to be a CHC. We feel that the providers in Ujjain were extremely cautious to project themselves to be working within the limits of the law. The

scare on account of the inspections under the PNDT Act might have affected the response of providers in Ujjain in various ways **(See Table 32).**

Sixty nine percent of the abortions conducted in CHCs were up to 12 weeks. Twenty percent of them were from 12-20 weeks and the rest 10% were for above 20 weeks. On the whole 19.67 abortions were conducted in a month in the two CHCs. In the District /civil and the other public hospitals 231.33 abortions were conducted in a month. Of them 69% were in the up to 12 weeks category and 31% were in the 12-20 weeks category. There were no abortions conducted in this group of hospitals for the above 20 week of pregnancies. Among the certified private institutions, 79% of abortions conducted were in the up to 12 weeks category, 21% belonged to 12-20 weeks, while no abortions were conducted in the above 20-week category. In the non-certified institutions 95% of the abortions conducted were in the up to 12 weeks category. Four percent and one percent of abortions respectively were conducted in the 12-20 weeks category and the above 20 weeks category **(See Table 33).**

The mean number of abortions of less than 12 week old pregnancies for a month is 5.92 for the facilities in Ujjain, and more than double at 12.32 in Sidhi. The figures of Ujjain in this respect could be due to under reporting by providers, due to the fear of PNDT inspections. We should expect a higher mean for Ujjain, with the large population of a city and people from other areas also likely to come there to seek abortion. The mean number of abortions of less than 20 weeks conducted at facilities in Sidhi is also high at 7.28 per month, which is close to the corresponding figure of 8.86 for Ujjain **(See Table 34).**

In 46% of the public institutions abortion was postponed at least once in the last three months of fieldwork. Such instances occurred in 31% of private institutions also. Non availability of the provider (40%), instrument related reasons (40%) and equipment disorder (20%) were the reasons mentioned for the postponement / refusal of the services in the Public institutions. High Patient load was mentioned as one of the reasons by as much as 60% of public institutions. In 50% of private institutions, equipment disorder was the reason for postponement /

refusal. In another 25% of them the reason was instrument related **(See Table 35)**

As high as 82% of public facilities were open at night, while only 55% private abortion providing institutions were open during the night. In only 46% of the public facilities, doctor was available to the patient at night. In the private institutions, the corresponding percentage was still less at 41%. Trained nurses were available at night in 36% of public and 10% of private institutions. Over-night staying facility was available at 91% of public and (49%) of private facility **(See Table 36)**

Blood transfusion facility was available in 36% of public institutions and 20% of private institutions. Referral to other hospitals was resorted to for Blood Transfusion in 55% of public institutions and 43% of private institutions **(See Table 36).**

Referrals for managing complications were relatively less in public facilities. In the case of Excessive Bleeding and Perforation due to Peritonitis 64% and 55% of public facilities respectively managed the situation in-house. In the case of Septicaemia, Shock and infection also 55%, 55% and 40% of institutions respectively managed them in-house **(See Table 37).**

The percentage of institutions, which managed complications in house were comparatively less in the private institutions. For excessive bleeding and Perforation due to Peritonitis, only 39% and 33% of private institutions did the management in house. Septicaemia, shock and infection were also managed in house by only 33%, 39% and 37% of private institutions compared to a higher percentage of public institutions as mentioned above. Immediate referrals after complications developed and referrals after stabilisation, from private institutions ranged from 47% in the case of both Shock and Infection to 59% in the case of Septicaemia. It could therefore be inferred that many private institutions lacked the facilities to manage abortions, if complications arose **(See Table 37).**

A relatively larger percentage of public institutions received women with post-abortion complications compared to private institutions viz. 82% and 78% respectively. In the last three months preceding the survey, the public institutions received on an average 3.82

cases of post abortion complications. This average was relatively less at 3.01 for private institutions **(See Table 38)**

Incomplete abortions and Haemorrhage were the two post abortion complications, which were taken in the public as well as private institutions. However, the percentages of institutions, which saw these complications showed a wide variation. Incomplete abortion cases were received in 82% of public institutions while only 59% of private institutions received such cases. Haemorrhage cases were received in 73% of public institutions, while only 55% of private institutions did so. In the case of shock and perforation also there was a wide variation in the percentage of institutions, which received cases. Fiftyfive percent of public institutions received cases of shock and perforation, while only 8% private institutions received cases of shock and only a slightly higher 14% received cases of perforation **(See Table 38).**

Ten of the 11 public institutions i.e. 91% of them were offering services such as Antenatal Care, Delivery, Postnatal care, contraception, Management of Post abortion complications, Treatment of STD/ HIV and infertility management. Antenatal care (96%) Post natal care (90%), contraception (88%), Management of Post Abortion complications (87%), were the services that were offered in most of the private institutions. Other Gynaecological problems were attended to in only 33% of private institutions, while 82% of public institutions were attending to them. Vaginal procedures were conducted in 51% of private institutions while 73% of public institutions did so. In the case of laparotomy and Lapraroscopy the variation between public and private institutions is very wide. Laparotomy: public – 55% and private 22%. Lapraroscopy: Public – 73% and private – 12% **(See Table 39).**

4.1. Referral Patterns

Majority of the public institutions i.e. 55% did not refer abortion patients. The corresponding category in private sector was less at 22%. It appeared that the large public hospitals had the capacity to handle abortion cases themselves. Only 9% public institutions and 29% of private institutions had formal or informal referral arrangements with other hospitals. In the case of 27% of the public and 45% of private institutions, there was no kind of referral arrangement with any other

institution. But this does not mean that they did not refer. The percentage of institutions, which did not refer at all have been separately mentioned above already **(See Table 40).**

In the one public institution, which had a referral arrangement with another hospital, the referred patient got priority treatment. This also applied to 80% of private institutions, which had referral arrangements. In 20% of private institutions with referral arrangements the patients reverted back after treatment, whereas this was not reported in public hospitals **(See Table 40)**. Facilities referring out more than 50% cases were only 9% in public facilities and only 10% in private facilities. Some elective abortions were referred out in 36% of public and 77% of private facilities. Majority of (55%) public institutions did not refer abortion cases **(See Table 41).**

All the four public facilities, which referred abortion cases, did so for 2nd trimester abortions and on account of medical risk cases. In the private sector also 87% and 79% respectively referred the 2nd trimester abortions and medical risk cases. Out of the four public institutions which referred 50% referred to District / Civil and other public hospitals, while the rest referred to one medical college. A substantially large 41% of private institutions referred cases to the District / civil hospitals or maternity homes. Five percent and three percent among them respectively referred to Community Health Centres and Medical Colleges **(See Table 41).**

Table 30: Facilities that are Functional

Facilities that are Functional	Ujjain		Sidhi		Total	
	No. of facilities	Providing abortion services %	No. of facilities	*oviding abortion services*	No. of facilities	Providing abortion services %
Public						
PHC	5	Nil	15	Nil	20	Nil
CHC	Nil	NA	4	50.0% (2)	4	50.0% (2)
District Hospital/Civil hospital/ Maternity Home/ Public Sector Undertaking	6	100.0% (6)	3	100.0% (3)	9	100.0% (9)
Certified Private	9	100.0% (9)	2	100.0% (2)	11	100.0% (11)

Table 31: Gestation of Pregnancy for which Services are Offered

Gestation of Pregnancy	Public		Private		All
	CHC N= 2 %	Dist / other hospitals N = 9 %	Certified N = 11 %	Not Certified N = 40 %	Total N = 62 %
<=12 weeks	50.0% (1)	55.5% (5)	72.7% (8)	85.0% (34)	75.8% (48)
<=20 weeks	Nil	44.4% (4)	27.3% (3)	5.0% (2)	14.5% (9)
> 20 weeks	50.0% (1)	Nil	Nil	7.5% (3)	6.4% (4)
No response	Nil	Nil	Nil	2.5% (1)	1.6% (1)

Table 32: District wise Data on Gestation of Pregnancy for which Abortion Services are offered

Gestation of Pregnancy	Ujjain N=31	Sidhi N= 31	Total N=62
Up to12 Weeks	77.41% (24)	77.41% (24)	77.41% (48)
Up to 20 weeks	22.58% (7)	6.45% (2)	14.51% (9)
Above 20 weeks	0	12.90% (4)	6.45% (4)
No Response	0	3.22% (1)	1.61% (1)
Total	**31**	**31**	**62**

Table 33: Number of MTPs Conducted per Month

No. of MTPs conducted per month	Public		Private		All
	CHC N = 2 %	Dist /Other hospitals N = 9 %	Certified N = 11 %	Not Certified N = 40 %	Total N = 62 %
<=12Weeks	69.49% (13.67)	68.6% (158.67)	78.6% (55.00)	94.9% (338.33)	80.88% (565.67)
Mean	*6.84*	*17.63*	*5*	*8.46*	*9.12*
Range for three months	*(18 - 23)*	*(2 – 180)*	*(3 – 60)*	*(2 - 280)*	*(2 – 280)*

	N=1	*N=3*	*N=3*	*N=6*	*N=13*
13-20 weeks	20.34% (4)	31.4% (72.67)	21.4% (15)	3.9% (14)	18.23% (105.67)
Mean Range for three months	*4 (12)*	*24.22 (3 – 130)*	*5 (3 – 28)*	*2.33 (3 – 14)*	*8.13 (3 – 130)*
	N=1	***N=0***	***N=0***	***N=3***	***N=4***
>20 weeks	10.17% (2)	Nil	Nil	0.84% (3)	0.88% (5)
Mean Range for three months	*2 (2)*	*NA*	*NA*	*1 (3 – 6)*	*1.25 (3– 6)*
No response	Nil	Nil	Nil	1	1
Total MTPs done	**19. 67**	**231. 33**	**70**	**356. 33**	**676. 33**

Table 34: District wise Data on Number of MTPs Conducted per Month

	Ujjain N=31	Sidhi N=31	Total N=62
< =12Weeks	183.67	382**	565.67
Mean	*5.92*	*12.32*	*9.12*
	N=7	***N =6***	***N = 13***
13= 20 weeks	62	43.67	105.67
Mean	*8.86*	*7.28*	*8.13*
	N =0	***N = 4***	***N = 4***
>20 weeks	0	5	5
Mean	*0*	*1.25*	*1.25*
Total	**245. 67**	**430. 67**	**676. 33**

** Total 269 (70%) abortions were done by 29 non-certified private facilities in Sidhi district.

Table 35: Need to postpone / refuse service provision because of logistic reasons

	Public N = 11 %	Private N = 51 %	All N = 62 %
Facilities where this occurred At least once in last three months	45.5% (5)	31.4% (16)	33.9% (21)
Information not Available	9.1% (1)	3.4% (2)	4.8% (3)
Reasons for postponing Services	*N=5*	*N=16*	*N=21*
Equipment out of order	20.0% (1)	50.0% (8)	42.8% (9)
Provider not there	40.0% (2)	18.7% (3)	23.8% (5)
Instruments related	40.0% (2)	25.0% (4)	28.6% (6)
Consumables related	Nil	Nil	Nil
Too high a patient load	60.0% (3)	87.5% (14)	80.9% (17)

Table 36: Ability of facility to function for Emergency cases /non routine hours

	Public N = 11 %	Private N = 51 %	All N = 62 %
Facility open at night	81.8% (9)	54.9% (28)	59.7% (37)
Facilities not open at night	18.2% (2)	45.1% (23)	40.3% (25)
Person available to see woman at night			

Doctor	45.5% (5)	41.2% (21)	41.9% (26)
ANM	Nil	3.9% (2)	3.2% (2)
Trained nurse	36.4% (4)	9.8% (5)	14.5% (9)
Overnight Staying Facility available	90.9% (10)	49.0% (25)	56.5% (35)
Information not available	9.0% (1)	4.0% (2)	5.0% (3)
Blood transfusion Facility			
Blood transfusion Facility available in house	36.4% (4)	19.6% (10)	22.6% (14)
Refer to other hospital for Blood transfusion	54.5% (6)	43.1% (22)	45.2% (28)
No arrangement	9.1% (1)	3.9% (2)	5.0% (3)
Information not available	Nil	31.4% (16)	25.8% (16)

Table 37: Management of Abortion Complications

	Public N = 11 %	Private N = 51 %	All N = 62 %
Excessive Bleeding			
Referred out	Nil	25.5% (13)	21.0% (13)
Stabilised and referred	27.3% (3)	31.4% (16)	30.6% (19)
Managed in house	63.6% (7)	39.2% (20)	43.5% (27)
Perforation peritonitis			
Referred out	Nil	43.1% (22)	35.5% (22)
Stabilised and referred	36.4% (4)	19.6% (10)	22.6% (14)
Managed in house	54.5% (6)	33.3% (17)	37.1% (23)
Other Complications			
Septicaemia			
Referred out	Nil	37.2% (19)	30.6% (19)
Stabilised and referred	36.4% (4)	21.6% (11)	24.2% (15)
Managed in house	54.5% (6)	33.3% (17)	37.1% (23)
No response	Nil	3.9% (2)	3.2% (2)
Shock			
Referred out	9.1% (1)	25.5% (13)	22.6% (14)
Stabilised and referred	18.2% (2)	21.6% (11)	21.0% (13)
Managed in house	54.5% (6)	39.2% (20)	41.9% (26)
No response	9.1% (1)	9.8% (5)	9.7% (6)
Infection			
Referred	Nil	27.5% (14)	22.6% (14)
Stabilised and referred	18.2% (2)	19.6% (10)	19.4% (12)
Managed in house	63.6% (7)	37.3% (19)	41.9% (26)
No response	9.1% (1)	11.8% (6)	11.3% (7)
Information not Available*	9.1% (1)	3.9% (2)	4.8% (3)

Table 38: Actual No. Of Emergency Cases Seen

Post Abortion Complications	Public N = 11 %	Private N = 51 %	All N = 62 %
Facilities which receive women with post abortion complications	81.8% (9)	78.4% (40)	79.0% (49)
Facilities which receive women with post abortion complications	9.1% (1)	17.6% (9)	16.1% (10)
Information not Available**	9.1% (1)	3.9% (2)	4.8% (3)
Average no of post abortion complications in last three months. (Only those facilities that receive cases) *(mean & range)*	3.82 (1-17)	3.01 (1-29)	3.16 (1-29)
Commonly seen complications			
Incomplete Abortion	81.8% (9)	58.8% (30)	62.9% (39)
Septicaemia	54.5% (6)	36.0% (18)	39.3% (24)
Haemorrhage	72.7% (8)	54.9% (28)	58.1% (36)
Shock	54.5% (6)	7.8% (4)	16.1% (10)
Perforation	54.5% (6)	13.7% (7)	21.0% (13)
Pelvic Inflammatory Disease	54.5% (6)	23.5% (12)	29.0% (18)

Table 39: Facilities Offering Other Types of RH services

Type of Reproductive Health Services	Public N = 11 %	Private N = 51 %	Overall N = 62 %
Antenatal care	90.9% (10)	96.0% (49)	95.2% (59)
Delivery	90.9% (10)	60.8% (31)	66.1% (41)
Postnatal care	90.9% (10)	90.2% (46)	90.3% (56)
Contraception	90.9% (10)	88.0% (45)	88.7% (55)
Management of Post abortion complications	90.9% (10)	86.3% (44)	87.1% (54)
Treatment of STD/HIV	90.9% (10)	56.9% (29)	63.0% (39)
Infertility management	90.9% (10)	70.6%(36)	74.2% (46)
Other gynaecological problems	81.8% (9)	33.3% (17)	42.0% (26)
Vaginal Procedures	72.7% (8)	50.9% (26)	54.8% (34)
Laparotomy	54.5% (6)	21.6% (11)	27.4% (17)
Laparoscopy	72.7% (8)	11.8% (6)	22.6% (14)
Information not Available**	9.1% (1)	3.9% (2)	4.8% (3)

Table 40: Referral Linkages

Type of Referral Arrangements	Public N = 11 %	Private N = 51 %	All N = 62 %
Formal /informal referral arrangement with another hospital exists	9.1% (1)	29.4% (15)	25.8% (16)
No referral arrangement	27.3% (3)	45.1% (23)	41.9% (26)
Do not refer	54.5% (6)	21.6% (11)	27.4% (17)
Information not Available**	9.1% (1)	3.9% (2)	4.8% (3)
Type of arrangement	***N=1***	***N=15***	***N=16***
Patients get priority treatment	100.0% (1)	80.0% (12)	81.2% (13)
Patients reverted back after getting care	Nil	20.0% (3)	18.3% (3)
Patient gets discount	Nil	Nil	Nil
Doctor gets referral fee	Nil	Nil	Nil

Table 41: Referral Patterns

Referral Patterns	Public N = 11 %	Private N = 51 %	All N = 62 %
Facilities referring out at least some elective abortion cases	36.4% (4)	76.5% (39)	69.4% (43)
Facilities referring out > 50% of cases	9.1% (1)	9.8% (5)	9.7% (6)
Facilities who do not refer abortion cases	54.5% (6)	19.6% (10)	25.8% (16)
Information not Available**	9.1% (1)	3.9% (2)	4.8% (3)
Types of cases commonly referred	***N=4***	***N=39***	***N=43***
2nd trimester abortion	100.0% (4)	87.2%% (34)	88.4% (38)
Incomplete abortion from elsewhere	Nil	17.9% (7)	16.3% (7)
Medical risk	100.0% (4)	64.1% (25)	67.4% (29)
Places where referral is made			
CHC	Nil	5.1% (2)	4.7% (2)
Dist/ Civil and Maternity home	50.0% (2)	41.0% (16)	41.9% (18)
Medical College	50.0% (2)	2.6% (1)	6.9% (3)

* *This is applicable to rest of the answers of this table

V. Technical Quality: Performance Standards of Facilities and Providers

5.1. Medical Standards

It was noticed that none of the public or private facilities were having service guidelines (**See Table 42**). For abortions up to 8 weeks many of the formally trained providers used D&C (38%) and Manual Vacuum Aspiration (MVA). Several of the not formally trained providers used D&C (50%). Homeopathic medicines were also reportedly used by 39% of not formally trained providers. In the case of abortions between 9-12 weeks, large number of formally trained providers used D&C (45%) while 58% of not formally trained providers also used the same method. Homeopathic medicines were used by 19% of non formally trained providers (**See Table 43**).

Only 36% of formally trained providers and 15% of not formally providers were conducting second trimester abortions. Majority of formally trained providers i.e. 53% used D&C for second trimester abortions. Intra Amniotic (7.1%) and Extra Amniotic (5%) methods were also used by a small number of formal providers **(See Table 44).**

To control the pain of abortions up to 8 weeks 93% of formally trained providers used analgesics and sedatives, while local anaesthesia was used by 67% of them. The pattern was the same with reduced percentage for the not formally trained providers also: 58% of them used analgesic and sedatives, while 42% used local anaesthesia **(See Table 45).**

In the case of 9-12 weeks abortions also 79% of formal providers used analgesics and sedatives, while 67% used local anaesthesia. General anaesthesia was used by 14% of formally trained providers. Half of the not formally trained providers also used analgesics and sedatives for 9-12 weeks abortions, while local anaesthesia was used by 42 % of them **(See Table 45).**

Analgesia & sedatives and General Anaesthesia were used for pain control for second trimester abortion by majority of formally trained providers. The respective percentages for formally trained providers

were Analgesics & Sedatives 73% and General Anaesthesia 53%. While 75% of not formally trained providers also used analgesics, sedatives and local Anaesthesia, all of them used general anaesthesia **(See Table.46).**

It appeared that only few providers were doing abortions above 20 weeks, which is not legally sanctioned also. Among the two formally trained providers who were doing abortions above 20 weeks, one was using local anaesthesia, while both used analgesics and sedatives. One provider from among not formally trained providers who did such abortions also mentioned only local anaesthesia for pain control **(See Table 46).**

General physical examination was conducted by large majority of the formally trained i.e. 98% and not formally trained providers i.e. 81%. Pelvic examination was done by 60% of formally trained providers, while only 23% of not formally trained providers conducted it. Abdominal examination was conducted by 45% of formally trained, while only 31% of not formally trained providers conducted it **(See Table 47).**

Among the formally and not formally trained providers, the percentage who prescribed antibiotics was 91% and 73% respectively. Iron tablets were prescribed by a relatively less percentage from among both categories i.e. 31% of formally trained and 12% of not formally trained. Analgesics were prescribed by a higher 71% of formally trained providers and by only 58% of not formally trained providers. Among the other drugs prescribed by both categories of providers were Mythargin, which was prescribed by 24% of formally trained and 12% of not formally trained providers and drugs like R.B tonic, Tetanus Toxoids, Vevron 1 BD prescribed by less than 5% of both the categories. Some of the drugs included in the category of other drugs were Homeopathic drugs **(See Table 48).**

5.2. Information & Counseling

The responses of providers, which are dealt with in this sub section are likely to be exaggerated. It is not possible to check these responses without conducting a user study of the same providers.

According to the information given by the providers, all the 42 formally trained providers (100%) and 96% of not formally trained providers were doing pre

abortion counselling. Among the formally trained providers 98% gave counselling on post abortion contraception 83% on complications and 79% on return of fertility. As regards the other providers 81% counselled on complications, 62% on contraception and 58% on return of fertility. Sixtyeight percent of formal providers and 54% of other providers counselled on pain **(See Table 49).** It is true that the above responses of providers for pre and post abortion counselling amount to very high claims by the providers. Such a high positive response regarding counselling could be doubted. But since the survey method is based on the stated responses of the research participants, this is a limitation of the study.

As in the case of pre abortion counselling 100% of formally trained providers and 96% of not formally trained providers were rendering post abortion counselling also. Follow up visits and post abortion medications were discussed by the highest percentage of formally trained providers viz 86% and 83% respectively. Other issues discussed were: contraception by 76% formally trained providers, danger signs by 71%, diet by 67%, sexual intercourse by 50% and work by 48%. Among the not formally trained also follow up visits and post abortion complication ranked as two issues on which counselling was given by a large percentage of them viz. 77% and 73%. Counselling on contraception and sexual intercourse were given by 58% of not formally trained providers. Other issues they gave counselling were: work- 54%, diet and danger signs 46% each **(See Table 50).**

As high as 95% of formally trained providers and 92% of not formally trained providers advised on routine follow up visits. Excessive bleeding, abdominal pain and vomiting were the circumstances when emergency follow up was advised by 95%, 91% and 71% of formally trained providers. Among the not formally trained providers 96% and 81% of them advised excessive bleeding and abdominal pain as the condition, which required emergency follow up **(See Table 51).**

All the 42 formally trained providers (100%) , offered contraceptive counselling, while this percentage was slightly less at 89% with the not formally trained providers. Majority i.e. 60% of formally trained providers offered

contraceptive counselling before the procedure, while 46% of not formally trained also did so. Fourteen percent of formally trained and 27% of not formally trained providers gave counselling on contraception after the procedure. As high as 95% of formally trained providers insisted on the method while a slightly less 77% of not formally trained providers also did insist on it. Tubectomy and IUD were the methods insisted by as high as 71% and 74% respectively of formally trained providers. On the contrary, only 50% of not formally trained providers insisted on Tubectomy. This could be due to the lack of technical knowledge of conducting tubectomy rather than out of an understanding to give reproductive choices to women. IUDs, Pills and Condoms were the methods insisted on by 62%, 65% and 58% of not formally trained providers **(See Table 52).**

Among the methods most popularly used by formally trained providers, Tubectomy, scored the highest score of 1.9 followed by IUD 2.1, Pills 2.6, Condoms 3.5, Vasectomy 4.8 and Injectables 5.1. The low scores of Condoms and Vasectomy need to be noted, though they are relatively harmless but male centred methods. A gender bias unfavourable to women is reflected here. In the case of not formally trained providers also this is reflected. Among them also the ranking scores are: Tubectomy 1.9, Pills 2, IUD 2.3, Condoms 2.7, Vasectomy 3.1 and Injectables. The preference to the relatively more harmful female methods is quite clear **(See Table 53).**

About 43% of formally trained providers would offer repeated abortions to the same clients. Another 17% would offer it with contraception also. At the same time 41% of formally trained and 31% of not formally trained providers would refuse to offer repeat abortions. Cultural biases against women who seek such abortions seem to be operating among a section of providers. However 69% of not formally trained providers also said that they would offer repeated abortions **(See Tab 53 A).**

5.3. Sterilisation/ Infection Prevention

Thirty six percentage of public facilities either washed the instruments in boiled water or boiled them for thirty minutes to sterilise, while 45% of private facilities washed instruments in boiled water. Autoclaving for disinfection was

done by 18% of public facilities, whereas a relatively higher percentage i.e. 37% of private facilities also adopted it **(See Table 54)**.

Twenty seven and thirty six percent of public facilities washed the rubber gloves either in savlon solution or bleaching powder. Twenty eight percent of private facilities also did so. Even though autoclaving was not suitable for rubber gloves 27% of public and 34% of private facilities did autoclaving for rubber gloves.

Most of providers sterilized Cannulae by washing in savlon solution. Around 54% of private facilities and a relatively higher percentage of public facilities (64%) sterilised cannulae in this manner.

A remarkably higher percentage of public and private facilities observe universal precautions in assisting, processing the surgical instruments, tissue samples and gloves etc. Ninety one percentage of public and 83% of private facilities dip the instruments in bleaching powder or chlorine solution for decontamination. To remove blood, tissue etc 82% of public facilities washed in boiled water, while 72% of private facilities followed it. Ninety one percent of public facilities and 89% private facilities did sterilization for high level disinfections **(See Table 54).**

A substantial percentage of public facilities either buried (56%) the Bio medical waste such as products of conception and blood, or disposed them in open pit or garbage (36%). Out of 35 private facilities where the Checklist was filled, 77% threw needles and syringes in open pit or garbage. A relatively larger percentage of public facilities (55%) than the private facilities (49%) were burying the products of conception and blood. The percentage of facilities using incineration to dispose various bio-medical wastes among private institutions varied from 5% to 16% while it was very marginal with only one institution doing it in public facilities **(See Table 55)**.

Table 42: Availability of Service Guidelines

Service Guidelines	Public N = 11 %	Private N = 51 %	Total N = 62 %
Guidelines Available	Nil	Nil	Nil
Types of Guidelines available	Not available	Not available	Not available
Information Not Available	9.1% (1)	3.9% (2)	4.8% (3)

Table 43: Techniques Used by Providers for Ist Trimester Abortions

	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
<=8 weeks			
MVA	30.9% (13)	3.8% (1)	19.7% (14)
EVA	19.0% (8)	7.7% (2)	14.1% (10)
D&C	38.1% (16)	50.0% (13)	40.8% (29)
D&E	4.8% (2)	Nil	2.8% (2)
Non-Allopathic Methods			
Homeopathic Medicines	2.4% (1)	38.5% (10)	15.5% (11)
Ayurvedic Medicines	4.8% (2)	Nil	2.8% (2)
9-12 weeks			
MVA	Nil	Nil	nil
EVA	19.0% (8)	7.7% (2)	14.1% (10)
D&C	45.2% (19)	57.7% (15)	47.9% (34)
D&E	9.5% (4)	Nil	5.6% (4)
Intra Amniotic Method	4.8% (2)	Nil	2.8% (2)
Extra Amniotic Method	2.4% (1)	Nil	1.4% (1)
Prostaglandin	2.4% (1)	Nil	1.4% (1)
Non-Allopathic Methods			
Homeopathic Medicines	2.4% (1)	19.2% (5)	8.4% (6)
Ayurvedic Medicines	2.4% (1)	Nil	1.4% (1)
Not Providing more than 8 weeks	9.5% (4)	15.4% (4)	11.3% (8)
Information Not Available**			4.2% **(3)**

Table 44: Techniques Used by Providers for 2nd Trimester Abortions

	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
Providers providing abortion for 2nd Trimester	35.7% (15)	15.4% (4)	26.8% (19)
Not providing for 2nd trimester	64.3% (27)	84.6% (22)	69.0% (49)
Information not Available			4.2% **(3)**
>13 Weeks	***N=15***	***N=4***	***N=19***
Extra amniotic	13.3% (2)	Nil	10.5% (2)
Intra amniotic	20.0% (3)	Nil	15.8% (3)
D & C	53.3% (8)	100.0% (4)	63.1% (12)
D & E	Nil	Nil	Nil
Prostaglandin	13.3% (2)	Nil	10.5% (2)

Table 45: Pain Control Methods Used for 1st Trimester Abortions

	Formally Trained N = 42 %	Not formally Trained N = 26 %	Total N = 71 %
< 8 weeks			
Analgesia /sedation	92.9% (39)	57.7% (15)	76.1% (54)
Local anaesthesia	66.7% (28)	42.3% (11)	54.9% (39)
General Anaesthesia	Nil	Nil	Nil
9-12 weeks			
Analgesia /sedation	78.6% (33)	50.0% (13)	64.8% (46)
Local anaesthesia	66.7% (28)	42.3% (11)	54.9% (39)
General Anaesthesia	14.3% (6)	3.8% (1)	9.9% (7)
Not Providing more than 8 weeks	9.5% (4)	15.4% (4)	11.3% (8)
Information not Available			4.2% **(3)**

Table 46: Pain Control Methods Used for 2nd Trimester Abortions

	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
13-20 weeks	***N=15***	***N=4***	***N=19***
Analgesia /sedation	73.3% (11)	75.0% (3)	73.7% (14)
Local anaesthesia	46.7% (7)	75.0% (3)	52.6% (10)
General Anaesthesia	53.3% (8)	100.0% (4)	63.2% (12)
> 20 weeks	***N=2***	***N=1***	***N=3***
Analgesia /sedation	100.0% (2)	Nil	66.7% (2)
Local anaesthesia	50.0% (1)	100.0% (1)	66.7% (2)
General Anaesthesia	Nil	Nil	Nil
Information not Available			4.2% **(3)**

Table 47: Pre discharge Examination

	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
General physical	97.6% (41)	80.8% (21)	87.3% (62)
Pelvic	59.5% (25)	23.1% (6)	43.7% (31)
Abdominal	45.2% (19)	30.8% (8)	38.0% (27)
Information not Available			4.2% **(3)**

Table 48: Drugs Routinely Prescribed after MTP

Drugs	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
Antibiotics	90.5% (38)	73.1% (19)	80.3% (57)
Iron	31.0% (13)	11.5% (3)	22.5% (16)
Vitamins	59.5% (25)	80.8% (21)	64.8% (46)
Analgesics	71.4% (30)	57.7% (15)	63.4% (45)

Uterotonics	Nil	Nil	Nil
Other			
R.B. Tonic	4.8% (2)	3.8% (1)	4.2% (3)
Mythargin	23.8% (10)	11.5% (3)	18.3% (18)
Tetanus Toxoids	4.8% (2)	Nil	2.8% (2)
Vevron 1 BD	2.4% (1)	Nil	1.4% (1)
Information not available			(3)

Table 49: Pre Abortion Counselling

	Formally Trained N = 42 %	Not formally Trained N = 26 %	Total N = 71 %
% who do pre abortion counselling	100.0% (42)	96.1% (25)	94.4% (67)
% who do not do pre abortion counselling	Nil	3.9% (1)	1.4% (1)
Information not Available			4.2% (3)
Issues discussed in Counselling			
Pain	66.7% (28)	53.8% (14)	59.2% (42)
Complications	83.3% (35)	80.8% (21)	78.9% (56)
Return of fertility	78.6% (33)	57.7% (15)	67.6% (48)
Post abortion contraception	97.6% (41)	61.5% (16)	80.3% (57)

Table 50: Post Abortion Counselling

Post Abortion Counselling	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
% who do post abortion counselling	100.0% (42)	96.1% (25)	94.4% (67)
% who do not give post abortion counselling	Nil	3.9% (1)	1.4% (1)
Information not Available			4.2% (3)
Issues discussed in Counselling			
Danger signs	71.4% (30)	46.1% (12)	59.2% (42)
Post abortion medication	83.3% (35)	73.1% (19)	76.1% (54)
Diet	66.7% (28)	46.1% (12)	56.3% (40)
Work	47.6% (20)	53.8% (14)	47.9% (34)
Sexual intercourse	50.0% (21)	57.7% (15)	50.7% (36)
Contraception	76.2% (32)	57.7% (15)	66.2% (47)
Follow up visit	85.7% (36)	76.9% (20)	78.9% (56)

Table 51: Information given on Follow up Visits

	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
% who advise routine Follow Up visit	95.2% (40)	92.3% (24)	90.1% (64)
% who do not advise routine Follow Up visit	4.8% (2)	7.7% (2)	5.6% (4)
Information not available			4.2% (3)
Average No. of days post abortion when visit is recommended *(Mean & Range).*	7.10 *(2-28)*	6.39 *(2-28)*	6.80 *(2-28)*

Circumstances when emergency follow up is advised			
Excessive bleeding	95.2% (40)	92.3% (24)	91.5% (64)
Abdominal pain	90.5% (38)	80.8% (21)	83.1% (59)
Vomiting	71.4% (30)	50.0% (13)	60.6% (43)
Fever	57.1% (24)	50.0% (13)	52.1% (37)
Foul swelling discharge	40.5% (17)	38.5% (10)	38.0% (27)

Table 52: Contraceptive Counselling

Contraceptive Counselling	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
% who offer contraceptive counselling	100.0% (42)	88.5% (23)	91.5% (65)
% who do not offer contraceptive counselling	Nil	11.5% (3)	4.2% (3)
Information not available			4.2% (3)
Timing of Contraception Counselling			
Before abortion procedure	59.5% (25)	46.1% (12)	52.1% (37)
During abortion procedure	2.4% (1)	Nil	1.4% (1)
After abortion procedure	14.3% (6)	26.9% (7)	18.3% (13)
Any time	23.8% (10)	15.4% (4)	19.7% (14)
Insistence on method	95.2% (40)	76.9% (20)	85.7% (60)
Do not Insistence on method	4.8% (2)	23.1% (6)	11.3% (8)
Information not available			4.2% (3)
Methods insisted on			
Vasectomy	14.3% (6)	7.7% (2)	11.3% (8)
Tubectomy	71.4% (30)	50.0% (13)	60.6% (43)
IUD	73.8% (31)	61.5% (16)	66.2% (47)
Pills	52.4% (22)	65.4% (17)	54.9% (39)
Condoms	31.0% (13)	57.7% (15)	39.4% (28)
Injectables	2.4% (1)	7.7% (2)	4.2% (3)

Table 52.A: Providers Response to Repeat Abortion Seekers

	Formally Trained N = 42 %	Not Formally Trained N = 26 %	Total N = 71 %
Provides abortion service	42.9% (18)	69.2% (18)	50.7% (36)
Refuses abortion service	40.5% (17)	30.8% (8)	35.2% (25)
Provides with Contraception	16.7% (7)	Nil	9.9% (7)
Information not available			4.2% (3)

Table 53: Methods Ranked by Providers as being most Popular

	Formally Trained N = 42	Not Formally Trained N = 26	Total N = 71
	Average rank	Average rank	Average rank
Vasectomy	4.8 (20)	3.1(14)	4.1 (34)
Tubectomy	1.9 (41)	1.9 (19)	1.9 (60)

IUD	2.1 (42)	2.3 (21)	2.2 (63)
Pills	2.6 (42)	2.0 (20)	2.4 (62)
Condoms	3.5 (37)	2.7 (19)	3.2 (56)
Injectables	5.1 (22)	3.2 (14)	4.4 (36)
Information not available			4.2% (3)

Table 54: Sterilization /Infection Prevention (Specified by criteria)

	Public N = 11 %	Private N = 35 %	Total N = 46 %
Instruments are sterilised as per standards			
Wash in boiled in water	36.4% (4)	45.7% (16)	43.5% (20)
Autoclave	18.2% (2)	37.1% (13)	32.6% (15)
Boiled for 30 minutes	36.4% (4)	14.3% (5)	19.6% (9)
Wash in Savlon solution	9.1% (1)	2.9% (1)	4.3% (2)
Rubber gloves are sterilised as per standards			
Wash in savlon solution	27.3% (3)	28.6% (10)	28.3% (13)
Wash in bleaching powder	36.4% (4)	28.6% (10)	30.4% (14)
Auto clave	27.3% (3)	34.3% (12)	32.6% (15)
Wash in hot water	9.1% (1)	8.6% (3)	8.7% (4)
Cannulae are sterilised as per Standards			
Wash in Savlon solution	63.6% (7)	54.3% (19)	56.5% (26)
Cidex solution	9.1% (1)	25.7% (9)	21.7% (10)
Steam boiler	9.1% (1)	2.9% (1)	4.3% (2)
Wash in hot water	9.1% (1)	8.6% (3)	8.7% (4)
Not applicable (No cannulae)	9.1% (1)	8.6% (3)	8.7% (4)
Steps of universal precautions- followed			
Dipping in bleaching powder, chlorine solution	90.9% (10)	82.9% (29)	84.8% (39)
No decontamination	9.1% (1)	17.1% (6)	15.2% (7)
Cleaning to remove blood, tissue etc.			
Washing in boiled water	81.8% (9)	71.4% (25)	73.9% (34)
Wash with surf/ soap	18.2% (2)	22.9% (8)	21.7% (10)
No	Nil	5.7% (2)	4.3% (2)
Rinsing with water to remove traces of chlorine solution			
Yes	90.9% (10)	77.1% (27)	80.4% (37)
No	9.1% (1)	22.9% (8)	19.6% (9)
Sterilisation/ high level infection			
Yes	90.9% (10)	88.6% (31)	89.1% (41)
No	9.1% (1)	11.4% (4)	10.9% (5)

Table 55: Waste Disposal Methods

	Public N = 11 %			Private N = 35 %			All N = 46 %		
	Products of conception and blood	Gloves	Syringes/ needles	Products of conception and blood	Gloves	Syringes/ needles	Products of conception and blood	Gloves	Syringes/ needles
Incineration	9.1% (1)	Nil	9.1% (1)	17.1% (6)	11.4% (4)	5.7% (2)	15.2% (7)	8.7% (4)	6.5% (3)
Burning	Nil	27.3% (3)	18.2% (2)	2.9% (1)	11.4% (4)	5.7% (2)	2.2% (1)	15.2% (7)	8.7% (4)
Bury	54.5% (6)	36.4% (4)	18.2% (2)	48.6% (17)	20.0% (7)	11.4% (4)	50.0% (23)	23.9% (11)	13.0% (6)
Open pit. Garbage	36.4% (4)	36.4% (4)	54.5% (6)	31.4% (11)	57.1% (20)	77.1% (27)	32.6% (15)	52.2% (24)	71.7% (33)

VI. ACCESSIBILITY OF SERVICES

6.1. Physical Access

Eighty two percent of public facilities and ninety one percent of private facilities were situated either on the roadside or close to the road. Bus service was available for 91% of public and 69% of private facilities. Hundred percent of public and private facilities were accessible by jeep or similar means of transportation **(See Table 56)**.

Even though all the eleven public facilities were approved by Govt. for MTP service, only 45% were having signboards, announcing MTP service and only 36% displayed the MTP certification. Compared to pubic facilities, still fewer private facilities i.e. 14% displayed MTP certification and signboard announcing MTP service **(See Table 56)**.

6.2. Financial Access

Despite the fact that public facilities were not permitted to charge for MTP, certain charges were reported in these institutions also. Seven of the 11 public facilities charged an average maximum amount of Rs. 285 for abortions of 12 week old pregnancies and 2 facilities charged an average maximum amount of Rs.775 for abortions up to 20 weeks. We doubt on the basis of qualitative information from the field that in the case of many public institutions, the above mentioned amounts are actually private payments to the concerned providers in the public sector and are not user charges. The costs of abortion in private facilities for different gestational periods were considerably higher. The average maximum cost of MTP service for up to 12 weeks gestation and up to 20 weeks were Rs.559 and Rs.1321 respectively. But few of the uncertified private providers with tiny clinics and with no formal training in MTP service were ready to make MTP available for Rs.30 to 50.

Out of 51 private facilities only 3 were providing MTP service for above 20 weeks. The mean maximum cost of MTP for above 20 weeks in private facilities was Rs. 1583. The range of maximum cost in private sector varied from Rs.1000 to Rs. 2250 **(See Table 57).**

In public facilities 46% of them included all the ancillary service costs such as drugs and investigation charges also in the abortion fee, while only 41% private facilities included all the ancillary costs in the abortion fee. Thirty six percent of public facilities included the cost of some such ancillary services in the MTP fee, while 43% of private facilities also incorporated the cost of some such services in the MTP fee.

Even though the costs of abortion in private facilities were high, 14% percent of private facilities charged the cost of ancillary services separately. Eighteen percent of public facilities also did so **(See Table 58).**

While analysed district wise we found that the charges for up to 12 week old pregnancies, which constitute the major chunk of the abortion care market is on the higher side in the less developed district of Sidhi as compared to the developed Ujjain district. The reason for this could be that Ujjain has a number of private providers, whose competition would bring down the charges, while the small number of private providers in Sidhi would be having more scope for dictating their charges. When it comes to 12 – 20 week pregnancy, which requires higher level of skills and facilities, the rates appear to be more uniform between the two districts. As per the information provided by the research participants, abortions of above 20 week pregnancies seem to be rarely done. **See Table (59).**

6.3. Social and Cultural/Woman's Perspective

Most of the providers were able to communicate in the local language. Ninety five percent of public providers and ninety four percent of private providers were able to communicate so (See Table 60).

The availability of female abortion providers in public facilities was considerably higher than in private facilities. Seventy three percent of public facilities were having at least one female abortion provider, while 55% of private facilities were not having even one female provider **(See Table 61).**

Out of 11 public institutions 73% provided abortion after multiple visits by the woman, while 63% of private facilities provided MTP service on the first visit itself. The reasons given by public facilities for multiple visits were the delay

due to the time taken for conducting tests such as BT&CT test, Haemoglobin test, Blood group test, Urine test and Pre Anaesthetic test etc. Although it could be possible that the private facilities were able to speed up these tests, it is also likely that theses facilities were hurrying up on abortions, not to lose clientele to other hospitals (**See Table 62**).

According to the MTP Act, recognised facilities are legally responsible to provide abortion even if a woman came alone. But out of 11 public facilities, only 27% provided abortion if a woman came alone. Only 36% of certified private facilities provided the service if women came alone. The percentage of uncertified private facilities offering MTP service, even when a woman came alone was reasonably higher than for the other two categories i.e. 42% **(See Table 63)**. But it could be that this was more of a market driven decision. In case a woman came with a friend but not with any family member, 82% of public facilities and 55% of certified private facilities would provide abortion, while 70% of uncertified private facilities also would offer the service. It was at the same time found that to the specific question on consent taken for abortions the percentage of those who gave abortions only with the women's consent fell to zero in the public sector and to just two in the private sector. Therefore even though a section of the providers in the public and private sectors are saying that they provided abortions to women who came alone this does not seem to reflect their actual practice.

Hundred percent of public facilities and 73% of certified private facilities would offer MTP service if the woman was a widow/separated or nullipara. Seventy three to eighty percent of uncertified private facilities would offer the service in that case. But in the case of women who were unmarried only 36% and 50% of certified and uncertified facilities respectively would offer the service, while a higher 73% of public facilities claimed that they would offer the service in that case also **(See Table 63).**

Table 56: Physical Accessibility

Distance from road	Public N = 11 %	Private N = 35 %	All N = 46 %
On road / < 1 km	81.8% (9)	91.4% (32)	89.1% (41)
>1 km	18.2% (2)	8.6% (3)	10.9% (5)
Type of public transportation available nearest to facility			
Bus	90.9% (10)	68.6% (24)	73.9% (34)
Jeep and similar	100.0% (11)	100.0% (35)	100.0% (46)
Signboard announcing MTP displayed	45.5% (5)	14.3% (5)	21.7% (10)
MTP certification displayed	36.4% (4)	14.3% (5)	19.6% (9)
Timing of clinic displayed	100.0% (11)	80.0% (28)	84.8% (39)

Table 57: Cost of Ser vices by Sector and Trimester of Pregnancy

Public Facilities (N = 11)	Minimum Cost *(Mean in Rs.& Range)*	Maximum Cost *(Mean in Rs. & Range)*
<= 12 weeks [No. of Hospitals charging in public sector]	Rs. 209.3 (60-800) [7]	Rs.285.7 (100-1000) [7]
13-20 weeks [No. of Hospitals charging in public sector]	Rs. 500.0 (500) [2]	Rs. 775.0 (750-800) [2]
>20 weeks [No. of Hospitals providing >20]	(Not Charging) [1]	(Not Charging) [1]
Private Facilities (N = 51)		
< =12 weeks [No. of Hospitals providing <=12 weeks]	Rs. 389.0 (30-1000) [50]	Rs.559.0 (50-1500) [50]
<=-20 weeks [No. of Hospitals providing <=-20 weeks]	Rs. 935.7 (500-1500) [7]	Rs.1321.4 (750-2000) [7]
> 20 weeks [No. of Hospitals providing >20 weeks]	Rs.1083.3 (750-1500) [3]	Rs.1583.3 (1000-2250) [3]
No Response	1	1

Note: Since some hospitals from Public and Private sector are not providing abortion above 12 weeks they are not applicable for 12 to 20 and above 20 weeks cost analysis.

Table 58: Inclusion of Ancillary Services in Cost of Service

Inclusion of Ancillary Services	Public N = 11 %	Private N = 51 %	Overall N = 62 %
Cost of All drugs/ lab tests etc included	45.5% (5)	41.2% (21)	41.9% (26)
Some medicines/investigations included	36.4% (4)	43.1% (22)	*41.9% (26)*
Medicines /investigations are included.	18.2% (2)	13.7% (7)	14.5% (9)
No response	Nil	2.0% (1)	1.6% (1)

Table 59: District wise Data on Cost of Services by Trimester of Pregnancy

Average cost	Ujjain		Sidhi		Total	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
< =12 Weeks	271.00	408.87	402.90	556.45	337.42	482.66
13 -20 weeks	850.00	1210.00	825.00	1187.5	838.88	1200.00
>20 weeks	0	0	1083.33	1583.33	1083.33	1583.33
No Response	Nil	Nil	1	1	1	1

Table 60: Providers who are able to Communicate in the Local Language

Provider's Ability to Communicate in local language	Public N = 19 %	Private N = 52 %	Total N = 71 %
Comfortable /somewhat comfortable	94.7% (18)	94.2% (49)	94.4% (68)
Uncomfortable	Nil	*1.4% (1)*	1.4% (1)
Information not available	5.3% (1)	3.8% (2)	4.2% (3)

Table 61: Facilities with Female Abortion Service Provider

	Public N = 11 %	Private N = 51 %	Overall N = 62 %
At least one female abortion service provider available	72.7% (8)	45.1% (23)	50.0% (31)
No female provider	27.3% (3)	54.9% (28)	50.0% (31)
Total	100.0% (11)	100.0% (51)	100.0% (62)

Table 62: Facilities Providing Service on same day as Woman's First Visit

	Public N = 11 %	Private N = 51 %	Total N = 62 %
Abortion on first visit	18.2% (2)	62.7% (32)	54.8% (34)
Multiple visits required	72.7% (8)	33.3% (17)	40.3% (25)
Information not available	9.1% (1)	3.9%% (2)	4.8% (3)
Reasons for Multiple visits			
BT& CT test	72.7% (8)	33.3% (17)	40.3% (25)
Haemoglobin test	63.6% (7)	27.5% (14)	33.9% (21)
Blood group test	63.6% (7)	27.5% (14)	33.9% (21)
Urine for albumin and sugar test	54.5% (6)	15.7% (8)	22.6% (14)
VDRL test	18.2% (2)	3.9% (2)	6.5% (4)
Check up for Anaemia	9.1% (1)	5.9% (3)	6.5% (4)
HIV test	Nil	2.0% (1)	1.6% (1)
Pre Anaesthetic test	36.4% (4)	5.9% (3)	11.3% (7)
Empty stomach is required	9.1% (1)	7.8% (4)	8.1% (5)
Proper counselling is required	9.1% (1)	2.0% (1)	3.2% (2)

Table 63: Circumstances Under which Facilities Provide Abortion

Provide Services under Following Conditions	Public N = 11 %	Private		All N = 62 %
		Certified N = 11 %	Not Certified N = 40 %	
Woman comes alone	27.3% (3)	36.4% (4)	42.5% (17)	38.7% (24)
Woman comes with friend, But without family member	81.8% (9)	54.5% (6)	70.0% (28)	69.4% (43)
Unmarried woman	72.7% (8)	36.4% (4)	50.0% (20)	51.6% (32)
Widow / separated / deserted	100.0% (11)	72.7% (8)	72.5% (29)	77.4% (48)
Married but has no children	100.0% (11)	72.7% (8)	80.0% (32)	82.3% (51)

VII. PROVISION OF ABORTION BY INFORMAL PROVIDERS

In the developed district of Ujjain we could identify 75 informal providers, who were providing abortion and in the less developed district of Sidhi we identified 95 informal providers. Altogether 170 informal providers were identified for the study.

The mean age of informal providers in the sample was around 37 years with very slight variation between the two districts. In age the sample ranged from 20–70 years, which was also reflected in the two sample districts also with minor differences only **(See Table 64)**.

In terms of gender there was a conspicuous presence of males among providers, with 59 male providers as against 16 females in Ujjain district and 72 males as against 23 females in Sidhi district. Altogether there were one hundred and thirty one males i.e. 77.05% and thirty nine i.e. 22.95% females.

In Ujjain, the more developed district, the percentage of providers having middle or high school education was 48%, while a remarkably higher percentage of providers i.e. 63% in less developed district of Sidhi, had middle or high school education. Meanwhile, in Ujjain district, forty one percent of informal providers were graduates compared to 23% in Sidhi district.

RMPs or Village Practitioners formed the major chunk of informal providers in both districts. Out of 170 informal providers 113 i.e. 67.47% were RMPs/ Village Practitioners. As the overall number of female abortion providers was very low, there were only 17 ANMs and 2 Nurses amounting to 11%.

The informal providers in the MP sample have had an average experience of 11 years. It was as high as 18 years in Sidhi and comparatively low at 12 years in Ujjain **(See Table 64)**.

All informal providers (100%) interviewed were treating delayed periods. Nearly two third of female informal providers i.e. 64%, used instruments to induce abortion while only 41% of males

accepted that they used instruments. Many a time male informal providers were reluctant to admit the usage of instruments, since they were probably more aware and therefore afraid of the legal complications. Eighty five percent of male informal providers said that they used injections for inducing abortion and 94% said that they gave tablets. Among the female informal providers, 77% and 69% used tablets and injections respectively for inducing abortion. Massage/pressure, herbs and decoction were mostly used by female informal providers i.e. 33% and 30% respectively **(See Table 65)**.

Fifty eight percent of male informal providers claimed that injections were successful in more than fifty percent of cases, while 46% of female informal providers also said that injections were successful.

Among the male informal providers 80% learned to treat women with delayed periods during private training, whereas 44% of female providers said that they learned it from Govt. training centres. Twenty five percent of female informal providers learned treating delayed periods from District hospitals. Many of the interviewed female informal providers were ANMs, LHVs and Nurses.

Out of 54 male informal providers who used instruments 46% of them used sharp metallic instruments, while 72% of female informal providers who used instruments were using Curette/ D&C for inducing abortion. Thirty nine and forty four percent of male informal providers used curette/D&C, Syringes respectively. Around twenty six to twenty eight percent of male and female informal providers used catheter for inducing abortion. Sixty seven percent of female informal providers also used blade/thread/cotton for abortion **(See Table 66)**.

Among the male informal providers the mean gestation period for which uterus evacuation was done using instruments was 8.3 weeks, with a range of 1-20 weeks. Correspondingly the mean gestation period for which the female informal providers used instruments was 9.3 weeks with a range of 1-23 weeks. The maximum of the range of gestation for which female providers used instruments was higher than the corresponding maximum of the range for males **(See Table 66)**.

The male informal providers treated an average of 2.2 cases per month with instruments, while a slightly higher average of 3.7 cases per month were treated by female providers. Both the categories got cases within a range of two to thirty per month **(See Table 66)**.

The average of maximum cost charged by female abortion providers was Rs.156 with a range of Rs.30 to Rs.415. The range of maximum cost among male abortion providers was Rs. 60 to Rs.670, which was higher than that of females, but with a relatively low average of maximum cost of Rs.120. The average of maximum cost of abortion among the informal providers of both sexes was Rs.129 **(See Table 67)**.

Among the 131 male providers 77% claimed that they got informal training in abortion during their privately, which they explained as their training during the courses they had passed. Another 12% had learned to do abortions in other Government training centres. The remaining 6% of them said that they learnt from District Hospitals. Among the female category, 42% learnt from various Government training centres, while 26% said that they had learnt from the district hospitals itself. Majority of female abortion providers were ANMs, LHVs or nurses, who had their training in Government institutions **(See Table 68)**.

Among the 170 informal providers all (100%) were treating delayed periods.

The range of services provided by informal providers was vast. Ninety two percent of informal providers gave injections. A good number of providers treated sprains/fractures and did sutures also. Sixty seven percent of providers attended deliveries. Among them 62% claimed that they conducted even complicated deliveries with breach presentation and excessive bleeding! More than ninety percent of informal providers claimed that they handled cases of incomplete abortions as well! Menstrual problems were attended to by almost all of them i.e. 99% **(See Table 69)**.

Table 64:Profile of Informal Providers Interviewed

Profile of Informal Providers	Ujjain N = 75 %	Sidhi N =95 %	Total N = 170 %
Average age in years *(mean & range)*	37.42 *(20- 70)*	37.02 *(20-65)*	37.2 *(20-70)*
Sex			
Female	21.3% (16)	24.2% (23)	22.9% (39)
Male	78.7% (59)	75.8% (72)	77.1% (131)
Educational Background			
Illiterate	4.0% (3)	6.3% (6)	5.3% (9)
Can read /write	2.7% (2)	Nil	1.2% (2)
Primary school	2.7% (2)	1.1% (1)	1.8% (3)
Middle /High school	48.0% (36)	63.2% (60)	56.5% (96)
Graduate	41.3% (31)	23.2% (22)	31.2% (53)
Post Graduate	1.3% (1)	6.3% (6)	4.1% (7)
Category of Provider			
ANM	12.0% (9)	8.4% (8)	10.0% (17)
LHV	1.3% (1)	2.1% (2)	1.8% (3)
Nurse	Nil	2.1% (2)	1.2% (2)
Compounder /pharmacist	Nil	1.1% (1)	.6% (1)
Lab /x ray technician	6.7% (5)	Nil	2.9% (5)
RMP/Village Practitioner	62.7% (47)	69.5% (66)	66.5% (113)
Dai /community worker	16.0% (12)	16.8% (16)	16.5% (28)
Male health worker	1.3% (1)	Nil	.6% (1)
Years of providing health services *(Mean in years & range)*	11.86 *(1-30)*	18.35 *(1-30)*	10.85 *(1-30)*

Table 65: Treatment for Delayed Periods by Informal Providers

Treatment for Delayed Periods	Male N = 131 %	Female N = 39 %	Total N = 170 %
Admitted to treating women with delayed periods	100% (131)	100% (39)	100% (170)
Types of treatment			
Massage /pressure	6.9% (9)	33.3% (13)	12.9% (22)
Herbs /concoctions	9.9% (13)	30.8% (12)	14.7% (25)
Tablets	93.9% (123)	76.9% (30)	90.0% (153)
Injections	84.7% (111)	69.2% (27)	81.2% (138)
Use instruments	41.2% (54)	64.1% (25)	46.5% (79)
Perception of success of various methods -successful in >50% of cases			
Herbs /concoctions	4.6% (6)	25.6% (10)	9.4% (16)
Tablets	37.4% (49)	30.7% (12)	35.8% (61)
Injections	58.0% (76)	46.1% (18)	55.3% (94)
Place from where provider learned to treat delayed periods			
District Hospital	6.1% (8)	25.6% (10)	10.6% (18)
Other govt. training Centre	9.2% (12)	43.6% (17)	17.1% (29)
During Private training	80.2% (105)	15.4% (6)	65.3% (111)

Working with Private Doctor	3.8% (5)	5.1% (2)	4.1% (7)
From In-laws	.8% (1)	10.3% (4)	2.9% (5)

Table 66: Instrumental Intervention to bring on an Abortion

Instrumental Intervention	**Male N = 131 %**	**Female N = 39 %**	**Total N = 170 %**
Admitted to using instruments to evacuate the uterus	41.2% (54)	64.1% (25)	46.5% (79)
Types of instruments used	***N=54***	***N=25***	***N=79***
Sharp metallic	46.3% (25)	36.0% (9)	43.0% (34)
Curette / D&C	38.9% (21)	72.0% (18)	49.4% (39)
Syringe	44.4% (24)	16.0% (4)	35.4% (28)
Catheter	25.9% (14)	28.0% (7)	26.6% (21)
Blade/ thread/ Cotton	1.9% (1)	16.0% (4)	6.3% (5)
Maximum gestation to which evacuation is done using instruments *(Mean & Range)*	8.3 (1-20)	9.3 (1-23)	8.6 (1-23)
Average No of Cases per month treated with instruments *(Mean & Range)*	2.2 (2-30)	3.7 (2-30)	2.7 (2-30)

Table 67:Average Amount Charged For abortion

Average amount Charged per case	**Male N = 131 %**	**Female N = 39 %**	**Total N = 170 %**
Average of Minimum charge *Range*	Rs. 84.3 *(30-475)*	Rs. 113.6 *(30-325)*	Rs. 91.0 *(30-475)*
Average of maximum charge *Range*	Rs.120.2 *(60-670)*	Rs. 156.3 *(60-415)*	Rs. 128.5 *(60-670)*

Table 68: Place from where Providers Learned

Place from where the provider Learned uterine evacuation	**Male N = 131 %**	**Female N = 39 %**	**Total N = 170 %**
District Hospital	6.1% (8)	26.3% (10)	10.1% (17)
Other govt. training Centre	11.5% (15)	42.1% (16)	18.3% (31)
During Private training	77.1% (101)	15.8% (6)	63.3% (107)
Working with Private Doctor	4.6% (6)	5.3% (2)	4.7% (8)
From In-laws	.8% (1)	10.3% (4)	2.9% (5)

Table 69: Other Services Provided by Informal Providers

Other Services Provided	**N= 170 %**
Injections	92.9% (158)
Stitches	74.7% (127)
Sprains /fractures	46.5% (79)
Snake bites	18.8% (32)
IV fluids	88.2% (150)
TT injections	92.4% (157)
Deliveries	67.1% (114)
Complicated deliveries	62.4% (106)
Incomplete abortions	91.8% (156)
Menstrual problems	99.4% (169)

VIII. CONCLUSION

8.1. Provision of Abortion

The provision of abortion services in the public sector is mainly concentrated in the urban areas. The PHCs, which are expected to provide the service to the rural women, are not offering it. No PHCs in the two sample districts of Ujjain and Sidhi were conducting abortion. Lack of an operation theatre or absence of a trained provider was cited as the reasons. Only 2 of the 4 CHCs in Sidhi were providing the service. In the developed district of Ujjain only a little over half of the public facilities which were supposed to provide abortion were doing so and in the less developed district of Sidhi only less than a quarter of them.

The number of Private formal abortion providing facilities identified in Ujjain was 42, out of which only 25 ie 60% participated in the study. At the same time 100 % (26) of the identified private formal providers in Sidhi participated in the study. We conclude that the high no-response rate (40%) in Ujjain can be attributed to the more organized nature of the providers in Ujjain, as it was a developed district, with more number of providers concentrated in one place. Apart from this the PNDT Act was also being somewhat strictly enforced in Ujjain when we were conducting our fieldwork.

Both the districts had a strong presence of informal providers, not only in the rural but also in the urban areas. Out of them we have interviewed 75 in Ujjain and 95 in Sidhi. We found that there were informal providers even in Ujjain city. Baidhan block, which is included in the sample from Sidhi district as the block with above average percentage of urbanization, was also having a large number of informal providers. We have interviewed 39 of them.

8.2. Certification

There was a very low level of certification among the private facilities / providers in both the districts. Only 36% of facilities in Ujjain had their site certified. Corresponding percentage in Sidhi was as low as 8%. Obviously the vast majority of formal abortion providers in MP have neither their sites certified nor are they themselves trained and registered to conduct abortions. Sixty four percent and 77% of facilities in Ujjain and Sidhi

respectively had never tried for registration also.

It was found that certification of facilities for conducting MTP was cumbersome procedure. The mean time gap between application and registration was as long as 7.18 months for both the districts together and the mean number of times application was refused was 2.73. All this would have prevented even well equipped facilities with trained medical personnel also from applying for certification. This partly explains why as many as 71 % of facilities did not apply at all for certification. True, many of them may not have met the required criteria specified in the MTP Act 1971 and its Rules. But there could have been at least some facilities, which met the criteria, but did not want to go through the bureaucratic formalities of certification.

There is also a serious lack of adequate institutions to train doctors in abortion procedures. Training facilities are restricted only to the five Medical Colleges in Madhya Pradesh and just 8 district hospitals in the state, which has as many as 45 districts according to the Census 2001.

8.3. Reporting and Consent

All the public facilities and only 55% of the certified private facilities reported the MTP cases to the Government.

All public facilities and an almost equally high 92% of private facilities took the consent of the women. Except in a little over one third of private institutions the consent was written in all other institutions.

Although as per the MTP Act only the woman's consent alone was necessary for conducting abortions, no public institution would do it so. Among private institutions only 2 % would do abortions only with the woman's consent. It is clear that in spite of an apparently progressive legislation, the woman's right to abort or retain a pregnancy is not culturally approved by the society. This social refusal of the woman's right to abort is getting reflected in the behaviour of the providers who seek the consent of the woman's husband and relatives in conducting abortions. Abortion procedure was mentioned in the consent forms of only 28% of private hospitals and higher 64% of public hospitals.

8.4. Physical Facilities Available in Institutions

Eighty nine percent of district, civil and other public facilities had visual and auditory privacy in the consulting room, while it was 100% among certified private facilities. In the case of uncertified private facilities the percentage for the two variables was relatively less than the other two categories of hospitals mentioned i.e. 67% and 50% respectively.

8.5. Place in Hospitals where MTP was done

Among the District hospital, civil hospital and other public institutions, which are supposed to have relatively better, 11% conducted abortions in the out patient department. Twenty three percent of uncertified private facilities also conducted abortions in their consulting room. Eleven percent of District, civil and other public hospitals conducted abortion in the procedure room. Among the private facilities also 18 % of certified and 27 % of uncertified facilities conducted abortion in the procedure room. How the requirements of equipment, instruments and that of privacy could be met when abortion were conducted in OPDs and consulting rooms causes concern.

8.6. Equipment / Instruments

It was possible to observe the abortion related equipment & instruments in all the public institutions. But a comparatively low 82% of certified and 88% of non certified private institutions only allowed us to do so. Yet, this rate in the private sector is high, compared to some other states where the study is being conducted simultaneously. Our strategy of keeping the researchers rather inconspicuous and projecting the apparently young and unthreatening but trained investigators seems to have paid off.

Fifty percent of CHCs had shadow less OT lamp while none of them had adjustable focus lamp. Shadow less OT lamp was available in 67% of Dist/ Civil and other public hospitals and 73% of certified private facilities while only 21% of uncertified private facilities were having it. Eighty nine percent of other public facilities and 91% of certified private facilities had adjustable focus lamp, while 50% of the uncertified private facilities also had it.

Sixty seven percent of District/Civil/other public hospitals and certified private facilities had electric

suction machine (ESM), whereas only 33% of not certified private facilities had ESM. Eighty nine percent of district, civil and other public hospitals and 67% of certified private hospitals had MVA syringe. Only 78% of district, civil and other public hospitals and 67% of certified private facilities had at least 3 different sizes of MVA cannulae. The availability of MVA syringe, cannulae and adapters among the uncertified private facilities were 67%, 67% and 56% respectively. Among the CHCs only 50% had the above-mentioned instrument.

Hundred percent of certified private facilities and CHCs had Sim's/ Cusco's speculum, Tenaculum/ Volsellum, Ovum forceps, Uterine curette. The availability of these instruments among the District/Civil/ and other public facilities and certified as well as uncertified private hospitals were on the higher side: above 85%. Dilator set was available for 50% of CHCs and 78% of district, civil other public hospitals, while 67% of certified private facilities had the set. Compared to other categories 91% of uncertified private facilities had complete set of Dilators.

A higher percentage of public and certified private hospitals had most of the anaesthetic equipment. Among the district and other public hospitals, 89% had Oxygen cylinders, 78% had Boyles apparatus as well as laryngoscope. The first two of these equipment were not available in both the CHCs, which in fact would be the main contact point for the rural people, as PHCs were not providing abortions. Not even half of the non-certified providers were having, either Oxygen cylinders, Boyles apparatus or laryngoscope.

The public and certified private hospitals showed a higher percentage of availability of various sterilization equipment such as Steam sterilizers, formalin chambers & autoclaves. The corresponding percentages were low for the non certified facilities.

8.7. Availability of Drugs

Among the drugs used for inducing abortion or cervical priming, Ethcrydine was available in only up to or less than 50% hospitals in the four categories of hospitals. Prostaglandin injection was not available at 100% of CHCs (2). It was available at 78% of the Dist/ Civil and other public hospitals, and an equal percentage of certified private institutions.

At the same time its availability dropped to only 43% in non-certified private institutions. In the case of Oxytocin injection except among the CHCs, where only 50% had it, the other three categories Viz. Dist/Civil and other public hospitals and the private institutions had a higher availability ranging from 89% to 100%.

8.8. Family Planning Devices

Tubectomy and IUD were the methods insisted by 71% and 74% of formally trained providers. Tubectomy scored the highest among the most preferred method of the providers. It appeared that commercial interests and the primacy given to tubectomy in the Govt. health sector were influencing the providers in the private sector also.

Temporary devices of FP such as Oral Pills and Condom were also available in both the CHCs in the sample, while IUD was available only in 50% of them. Condoms were available at 100% of district & other public hospitals, while 89% of them had Oral Pills & IUDs. The pattern found in the district & other public hospitals was also seen in the certified private facilities. But non-certified institutions showed a low availability of all these devices. Since female sterilisation seem to be the preferred method of providers, the mere availability of spacing methods does not amount to their utilisation.

8.9. Maintenance of Equipment

Only 10% of the institutions had taken annual maintenance contracts. It was highest among the District, Civil & public hospitals with 33% and lowest at 5% among the non certified providers. Twentynine percent of institutions had to depend on other cities for getting their equipment repaired. The low level of AMC contracts coupled with the fact that a large percentage of institutions do not have the facility to repair their equipment in the cities where they are located raises concerns about the timely delivery of abortion services.

8.10. Availability of Service Providers

There was at least one or more full time gynaecologist/MD/ MS/ DNB in Gynaecology & Obstetrics or DGO in 73% of public facilities and 45% certified private institutions. Only 15% of un certified facilities had full time gynaecologists. A small 9% & 13% of certified and non-certified private facilities had them visiting on specific days. Only

18% of uncertified facilities had full time MBBS doctors.

8.11. Provider Characteristics

There were 27% (19) public providers and 73% (52) private providers. Among them only 34% were MD/MS/ DNB in Gynaecology & Obstetrics or were DGOs. Trained providers with MBBS or MD/ MS in other branches were also only 16%. On an average the mean number of years of abortion practice of the providers was 13 years. The Mean age of the providers was 41.5 years, with a range of 24 – 65 years.

8.12. Training

Training in abortion was provided at only the 5 medical colleges in the state and eight district hospitals. The paucity of adequate training institutions also could be one of the reasons for the large number of untrained abortion providers in MP, who are catering to a market need, though improperly.

In terms of qualifications, very high 77% of the public providers were either MD / MS/DNB in Obstetrics & Gynaecology or DGOs. Among the private formally trained providers only 44% had such qualifications. The presence of large percentage of highly qualified providers in the public sector could be one of the reasons for more referrals from the private to the public sector in the case of complications. In the support areas of abortion such as counselling and interpersonal communication also a relatively higher 47% of public providers as compared to 21% of private providers had got trained. At the same time it should not be lost sight of that in terms of numbers the private providers who amount to 73%of the providers could be having a wider reach than the public providers, who come to only 27%.

8.13. Gestations for which Abortion Done

On the whole most of the abortions were conducted within first 12 weeks of pregnancy. Sixty nine percent of the abortions conducted in CHCs were up to 12 weeks. Twenty percent of them were from 12-20 weeks and the rest 10% were for above 20 weeks. All together only 19.67 abortions were conducted in a month in the two CHCs. On the contrary, in the District /civil and the other public hospitals 231.33 abortions were conducted in a month. Of them 69% were in the up to 12 weeks category and 31% were in the 12-20 weeks category. There were no

abortions conducted in this group of hospitals for the above 20 week of pregnancies. Among the certified private institutions, 79% of abortions conducted were in the up to 12 weeks category, 21% belonged to 12-20 weeks, while no abortions were conducted in the above 20-week category. In the non-certified institutions 95% of the abortions conducted were in the up to 12 weeks category. Four percent and 1% of abortions respectively were conducted in the 12-20 weeks category and the above 20 weeks category.

8.14. Postponement / Refusal

In 46% of the public institutions abortion was postponed at least once in the three months preceding the fieldwork. Such instances occurred in 31% of private institutions also. High Patient load was mentioned as one of the reasons by as high as 60% of public institutions. Non availability of the provider (40%), instrument related reasons (40%) and equipment disorder (20%) were the reasons mentioned for the postponement / refusal of the services in the public institutions. In 50% of private institutions, equipment disorder was cited as the reason for postponement / refusal. Mean days of time lag due to repairs was as high as 11-37 days in different categories of public hospitals and 4 to 5 days in certified & non certified institutions

8.15. Functioning at Nights

Eighty two percent of public facilities were open at night, while only 55% of private facilities did so. Doctors were available at night only in 46% of public facilities and a still less 41% of private facilities.

8.16. Managing Complications

The percentage of institutions, which handled in-house, the complications of abortion such as Excessive Bleeding, Perforation due to Peritonitis, Septicaemia, shock and infection was relatively higher in public than among private facilities. Immediate referrals after developing complications and referrals after stabilisation from private institutions ranged from 47% for shock to 59% for septicaemia. As regards management of post abortion complications, 82% of public institutions received cases of incomplete abortions, while only 59% of private institutions did so. Cases of Haemorrhage were taken in 73% of public institutions, while only 55% of private institutions treated them.

8.17. Other Reproductive Health Services

Several Reproductive Health Services were provided by around 90% of both public and private facilities. Other Gynaecological problems were attended to in only 33% of private institutions, while 82% of public institutions were attending to them. Vaginal procedures were conducted in 51% of private institutions while 73% of public institutions did so. In the case of Laparotomy and Lapraroscopy the variation between public and private institutions is very wide. Laparotomy: public – 55% and private 22%. Lapraroscopy: Public –73% and private – 12%.

8.18. Referral Patterns

Majority (55%) of public institutions treated abortion patients in house, even when they developed complications, where as only 22% of private institutions did so. The four public facilities, which referred cases, did so for 2nd trimester abortions and medical risk cases. In the private sector also 87% and 79% facilities respectively referred cases of these two categories. Not surprisingly, a large 41% of private facilities referred abortion cases to the District / Civil or other public hospitals.

8.19. Techniques Used & Pain Control

For abortions up to 8 weeks many of the formally trained providers used D&C (38%) and Manual Vacuum Aspiration (MVA). Several of the not formally trained providers used D&C (50%). In the case of abortions between 9-12 weeks, large number of formally trained providers used D&C (45%) while 58% of not formally trained providers also used the same method.

Only 36% of formally trained providers and 15% of not formally providers were conducting second trimester abortions. Majority of formally trained providers i.e. 53% used D&C for second trimester abortions. Intra Amniotic 7.1% and Extra Amniotic 5% methods were also used by a small number of formal providers.

8.20. Pain Control Methods

To control the pain of abortions up to 8 weeks 93% of formally trained providers used analgesics and sedatives, while local anaesthesia was also used by 67% of them. The pattern was the same with reduced percentage for the not formally trained providers also: 58% and 42% respectively.

In the case of 9-12 weeks abortions 79% of formal providers used analgesics and sedatives, while 67% also used local anaesthesia. General anaesthesia was used by 14% of formally trained providers. Half of the not formally trained providers used analgesics and sedatives for 9-12 weeks abortions, while local anaesthesia was used by 42 % of them.

Analgesia & sedatives and General Anaesthesia were used for pain control for second trimester abortion by majority of formally trained providers. The respective percentages for formally trained providers were Analgesics & Sedatives 73% and General Anaesthesia 53%. While 75% of not formally trained providers also used analgesics, sedatives and local anaesthesia, all of them used general anaesthesia.

It appeared that only few providers were doing abortions above 20 weeks, which is not legally sanctioned. Among the two formally trained providers who were doing abortions for above 20 weeks, one was using local anaesthesia, while both used analgesics and sedatives. One provider from among not formally trained providers who did such abortions also mentioned only local anaesthesia for pain control.

8.21. Pre discharge Examination

General physical examination was conducted by large majority of the formally trained i.e, 98% and not formally trained providers i.e, 81%. Pelvic examination was done by 60% of formally trained providers, while only 23% of not formally trained providers conducted it. Abdominal examination was conducted by 45% of formally trained, while only 31% of not formally trained providers conducted it.

8.22. Pre & Post Abortion Counselling & Follow Up Advice

All formally trained providers and 96% of not formally trained providers were providing pre and post abortion counselling. Excessive bleeding, abdominal pain and vomiting were the conditions for which follow up was advised by 95%, 91% & 71% respectively of formal providers. Ninety six percent of not formally trained providers advised follow up for excessive bleeding, while 81% of them advised for abdominal pain. It is true that the above responses of providers for pre and post abortion counselling amount to very high claims by the providers. Such a high positive response regarding counselling could be

doubted. But since the survey method is based on the stated responses of the research participants, this is a limitation of the study.

8.23. Contraceptive Counselling

All the 42 formally trained providers (100%), offered contraceptive counselling, while this percentage was slightly less at 89% with the not formally trained providers. Majority i.e. 60% of formally trained providers offered contraceptive counselling before the procedure, while 46% of not formally trained also did so. Fourteen percent of formally trained and 27% of not formally trained providers gave counselling on contraception after the procedure.

While giving counselling on FP methods before or after the procedure does not amount to coercive Family Planning, insistence on certain methods by the providers does amount to coercing the woman, when they are in a vulnerable situation seeking the providers help in getting an abortion done. As high as 95% of formally trained providers insisted on the FP method, while a slightly less 77% of not formally trained providers also did insist on it. Tubectomy and IUD were the methods insisted by as high as 71% and 74% respectively of formally trained providers. On the contrary, probably due to the lack of technical knowledge of conducting tubectomy, only 50% of not formally trained providers insisted on Tubectomy. IUDs, Pills and Condoms were the methods insisted on by 62%, 65% and 58% of not formally trained providers.

8.24. Access to Abortion Services

Eighty two percent of public and 91% private facilities were situated on the roadside or close to it. Bus service was available to reach 91% of public and 69% of private facilities.

8.25. Cost of Services

Seven of the 11 public facilities charged an average maximum amount of Rs. 285 for abortions of 12 week old pregnancies and 2 facilities charged an average maximum amount of Rs.775 for abortions up to 20 weeks. We doubt that in the case of many public institutions, these are partly or fully private payments to the concerned providers in the public sector and are not fully user charges. The cost of abortion in private facilities for different gestational periods was considerably higher. The average maximum cost of

MTP service in private sector for up to12 weeks gestation and up to 20 weeks were Rs.559 and Rs.1321 respectively.

Out of 51 private facilities only 3 were providing MTP service for above 20 weeks. The mean maximum cost of MTP for above 20 weeks in private facilities was Rs. 1583. The range of maximum cost in private sector varied from Rs.1000 to Rs. 2250.

8.26. Facilities with Female Providers

Seventy three percent of public facilities were having at least one female abortion provider, while 55% of private facilities were not having even one woman provider.

8.27. Circumstances under which Facilities Provide Abortion

According to the MTP Act, certified facilities are expected to provide abortion even if a woman came alone. But out of 11 public facilities, only 27% provided abortion if a woman came alone. Only 36% of certified private facilities provided the service if women came alone. The percentage of uncertified private facilities offering MTP service, even when a woman came alone was reasonably higher than for the other two categories i.e. 42%. But it could be that this was more of a market driven decision in order to attract clientele. In the case of a woman came with a friend but not with any family member, 82% of public facilities and 55% of certified private facilities would provide abortion, while 70% of uncertified private facilities also would offer the service. It was at the same time found that to the specific question on consent taken for abortions the percentage of those who gave abortions only with the women's consent fell to zero in the public sector and to just two in the private sector. Therefore even though a section of the providers in the public and private sectors are saying that they provided abortions to women who came alone this does not seem to reflect their actual practice.

From what appears from the responses of our research participants, the unmarried women would find it more difficult to get abortion done, compared to widowed or separated women. Hundred percent of public facilities and 73% of certified private facilities would offer MTP service if the woman was a widow/separated or nullipara. Seventy three to eighty percent of uncertified

private facilities would also offer the service in that case. But in the case of women who were unmarried only 36% and 50% of certified and uncertified facilities respectively would offer the service, while a higher 73% of public facilities claimed that they would offer the service in that case also.

8.28. Provision of Abortion by Informal Providers

8.28.1. Profile of the Informal Providers Interviewed

There was a conspicuous presence of males among the informal providers, with 59 male providers as against 16 females in Ujjain district and 72 males as against 23 females in Sidhi district. Altogether there were 77.5% males and 22.95% females in the overall sample of 170. RMPs or Village Practitioners formed the major chunk of informal providers in both districts. Out of the 170 informal providers 113 i.e. 67.47% were RMPs / Village Practitioners. As the number of female abortion providers was very low, there were only 17 ANMs and 2 Nurses amounting to only 11%. RMP-hood, to which the males could upgrade themselves more easily, given the general perception of the doctor as a male in rural areas, seems to have emboldened many men to take to provision of abortion.

8.28.2. Treatment of Delayed Periods by Informal Providers

All informal providers (100%) interviewed were treating delayed periods. Nearly two-thirds of female informal providers i.e. 64%, used instruments to induce abortion while only 41% of males mentioned that they used instruments. We felt that the male informal providers were generally reluctant to admit the use of instruments. Fifty eight percent of male informal providers and 46 % of female informal providers also claimed that injections were successful in more than fifty percent of cases.

8.28.3. Instrumental Intervention to Bring on an Abortion

Out of 54 male informal providers who used instruments 46% of them used sharp metallic instruments, while 72% of female informal providers who used instruments were using Curette / D&C for inducing abortion. Thirty nine and forty four percent of male informal providers used curette/D&C, Syringes respectively. Around twenty six to twenty eight percent of male and female informal providers used catheter for inducing abortion.

Among the male informal providers the mean gestation period for which uterus evacuation was done using instruments was 8.3 weeks, with a range of 1-20 weeks. Correspondingly the mean gestation period for which the female informal providers used instruments was 9.3 weeks with a range of 1-23 weeks.

The male informal providers treated an average of 2.2 cases per month with instruments, while a slightly higher average of 3.7 cases per month were treated using instruments by female providers. Both the categories got cases within a range of two to thirty per month.

8.28.4. Other services provided by informal providers

The range of other services provided by informal providers was vast. Ninety two percent of informal providers gave injections for various other illnesses. A good number of providers treated sprains/ fractures and did sutures also. Sixty seven percent of providers attended deliveries. Among them 62% claimed that they conducted even complicated deliveries with breach presentation and excessive bleeding! More than ninety percent of informal providers claimed that they handled cases of incomplete abortions as well! Menstrual problems were attended to by almost all of them i.e. 99%.

Appendix: I

Table I: District wise Status of Prenatal Diagnostic Test

S. No.	District	No. of Regi. Bodies		No. of Complaints Received	No. of Court Cases	Action Taken	Inspection up to June 2002
		Pvt.	Govt.				
1	Barwani	4	0	Nil	Nil	1 Sealed	4
2	Balaghat	9	0	Nil	Nil	1 Banned	11
3	Betul	5	2	Nil	Nil	1 sealed	
4	Bhind	7	0	1 not found guilty	Nil	Nil	7
5	Bhopal	107	13	Nil	Nil	10 sealed then registered on 7th May 02	90
6	Chhattarpur	2	0	Nil	Nil	Nil	
7	Chhindwara	17	3	Nil	Nil	Nil	
8	Damoh	4	0	Nil	Nil	Nil	
9	Datia	0	0	Nil	Nil	Nil	
10	Dewas	17	2	Nil	Nil	1 registration cancelled	25
11	Dhar	14	0	Nil	Nil	Nil	11
12	Dindori	0	0	Nil	Nil	Nil	
13	Guna	5	3	Nil	Nil	Nil	4
14	Gwalior	55	4	Nil	4	5	77
15	Harda	2	0	Nil	Nil	Nil	
16	Hoshangabad	14	0	Nil	Nil	Nil	9
17	Indore	127	3	Nil	6	6	117
18	Jabalpur	62	4	Nil	Nil	1 sealed	66
19	Jhabua	2	2	Nil	Nil	Nil	
20	Katni	8	0	Nil	Nil	Nil	8
21	Khandwa	13	0	Nil	Nil	Nil	12
22	Khargone	8	1	Nil	Nil	Nil	10
23	Mandla	4	0	Nil	Nil	Nil	6
24	Mandsaur	12	2	Nil	Nil	Nil	13
25	Morena	9	1	Nil	Nil	Nil	
26	Narsimhpur	5	1	Nil	Nil	Nil	1
27	Neemuch	9	0	Nil	Nil	Nil	9
28	Panna	1	0	Nil	Nil	Nil	
29	Raisen	0	1	Nil	Nil	Nil	3
30	Rajgarh	2	1	Nil	Nil	Nil	
31	Ratlam	16	3	Nil	Nil	Nil	2
32	Rewa	10	5	Nil	Nil	Nil	15
33	Sagar	15	0	Nil	Nil	Nil	15
34	Satna	19	1	Nil	Nil	Nil	
35	Sehore	4	1	1 not found guilty	Nil	Nil	9
36	Seoni	5	1	Nil	Nil	Nil	
37	Shahdol	6	1	Nil	Nil	Nil	

38	Shajapur	7	1	Nil	Nil	Nil	
39	Sheopur	1	1	Nil	Nil	Nil	6
40	Shivpuri	2	0	Nil	Nil	Nil	
41	**Sidhi**	**6**	**1**	**1 report Awaited**	Nil	Nil	**7**
42	Tikamgarh	2	0	Nil	Nil	Nil	
43	**Ujjain**	**25**	**1**	Nil	Nil	Nil	**26**
44	Umaria	0	0	Nil	Nil	Nil	
45	Vidisha	8	0	Nil	Nil	Nil	8
	Total	**650**	**59**	**3**	**10**	**16**	**571**

Source: *Dept. of Health & Family Welfare, Secretariat, Bhopal, 2002.*

Table II: MP District Level Indicators

S.No	District	Female Sex Ratio	Female Literacy Rate	Total Fertility Rate	IMR – 91 (Female	Couple Protection Rate	Institutional Deliveries
		1	2	3	4	5	6
Madhya Pradesh		912	28.8	4.92	136	NA	NA
1	Morena	826	20.8	6.63	116	29.60	26.40
2	Bhind	816	28.2	5.55	113	43.70	14.10
3	Gwalior	833	41.7	4.85	103	51.70	48.20
4	Datla	847	23.7	5.07	141	40.20	23.70
5	Shivpuri	849	15.6	5.39	139	33.80	22.00
6	Guna	875	18.0	5.85	144	36.70	29.00
7	Tikamgarh	871	20.0	6.24	153	45.50	21.50
8	Chhatarpur	856	21.3	5.55	149	31.90	19.10
9	Panna	897	19.4	5.68	129	25.60	10.10
10	Sagar	881	37.8	5.51	132	43.30	24.40
11	Damoh	905	30.5	5.13	139	41.10	8.70
12	Satna	918	27.8	5.54	147	35.10	13.30
13	Rewa	932	26.9	5.59	127	38.80	12.90
14	Shahdol	940	20.1	5.04	111	37.80	11.70
15	Sidhi	922	13.6	6.02	106	29.50	7.30
16	Mandsaur	945	28.3	4.10	112	48.70	25.60
17	Ratlam	948	29.1	4.68	132	52.60	31.00
18	Ujjain	929	32.6	4.17	74	57.50	41.00
19	Shajapur	918	19.8	5.00	118	44.10	29.00
20	Dewas	924	25.6	4.91	102	58.00	36.00
21	Jhabua	977	11.5	5.69	96	26.80	18.00
22	Dhar	951	20.7	4.97	102	45.80	17.50
23	Indore	906	53.3	3.81	69	67.40	62.30
24	West Minar	950	23.2	5.09	124	NA	NA
25	East Minar	938	31.5	5.18	131	51.50	21.90
26	Rajgjar	923	15.6	5.22	144	33.30	18.90
27	Vidisha	874	27.8	5.55	102	40.90	19.60
28	Bhopal	889	54.2	4.79	98	60.80	52.50
29	Sehore	898	22.0	5.23	117	45.20	23.00

30	Raisen	879	25.5	6.14	159	52.50	15.90
31	Betul	966	33.9	5.32	141	61.20	25.50
32	Hoshangabad	899	37.6	4.67	139	48.50	32.60
33	Jabalpur	915	45.0	4.57	117	44.00	31.60
34	Narsimhapur	913	41.0	3.95	121	54.10	17.80
35	Mandla	988	22.2	4.09	104	50.70	10.70
36	Chhindwara	953	32.5	5.15	116	51.70	18.90
37	Seoni	974	31.1	4.27	118	50.80	13.90
38	Balaghat	1002	38.9	3.92	147	49.50	12.30
39	Surguja	956	17.4	4.28	95	32.60	11.80
40	Bilaspur	978	27.3	4.71	91	35.10	13.40
41	Raigarh	1000	26.5	4.03	107	33.30	18.90
42	Rajnandgaon	1012	27.8	4.20	124	45.00	10.50
43	Durg	967	42.8	4.22	84	51.90	21.10
44	Raipur	993	31.0	4.33	122	42.50	11.70
45	Bastar	1002	15.3	4.49	86	36.30	11.80

Sorce: 1-4: *Census of India1991, Fertility & Mortality Indicators at the District Level 1997*, 5-6: *RCH District Level Data.*

Appendix: II

Quality of Care Index

The table I shows the mean scores of various aspects of quality of abortion services, derived based on the methodology adopted for the calculation of these indices which are described elsewhere in this Appendix. The district wise calculation of the quality care index shows the following features.

For Accessibility, for which the possible scale value ranges from 0-5, the less developed district of Sidhi has a mean score of 4.84 while the more developed district of Ujjain has 4.76. The Accessibility score was calculated on the basis of distance of the facility from motorable roads. The scale value range for privacy score is 3-6 for which Ujjain district is having a higher mean of.5.71. The corresponding value for Sidhi district is 4.76. Ujjain and Sidhi, are having physical standards scores of 2.86 and 2.04 respectively, for which the range of scale value is 0-3. The privacy score was measured on the basis of auditory and visual privacy in the consulting room and in the recovery room. The scale value range for clinical standards of drugs used for abortion is 0-11 for which Ujjain was having a higher mean of 9.14 while Sidhi's score was low at 6.8. The scale value range for Clinical standards of equipment used for abortion was 0-17 for which Ujjain district scored 14.09, while Sidhi district scored 11.56. The physical standards, clinical standards of drugs and equipment were calculated on the basis of condition of operation table, availability of drugs for abortion and availability of equipment used for abortion respectively.

The technical competence of each district was measured in terms of the technical qualification of the doctors available in the facilities located in the districts, the availability of blood bank in facilities and whether they are open at night. The total score of these three variables was taken as the score for technical competence of the facilities. The score for the district's technical competence was obtained by adding up the values for the facilities. Ujjain and Sidhi districts were having a low mean for Technical competence i.e. 6.48 and 5.48 respectively, while the possible score

ranged from 1-21. The availability score was obtained for the values given for different methods of MTP services provided during the three months preceding the fieldwork, for each gestation period and the value for each gestation. The possible scale value varies from 0-14 while the mean obtained by Ujjain and Sidhi districts were 4.12 and 4.90 respectively.

We find while analysing the Accessibility, Privacy and Clinical Standards of equipment that the public facilities were scoring higher than the private institutions, while in physical standards and clinical standards of drugs the private sector facilities were scoring marginally higher than the public institutions. In terms of technical competence and availability score again the public sector was scoring considerably higher than the private sector.

The variation in denominators between the various segments of the Quality Index prevents us from calculating a composite Quality Index. The means for the scores of Accessibility, Privacy, Physical Standards, and Clinical Standards for Drugs and Equipment are based on the 46 observed and oral responses to the Facility Assessment Checklist, while the scores for Technical Competence and Availability are based on the 62 responses from the facilities taken from the Administrative or Provider Schedules.

Table I: Aspects of Quality of Care Index: District wise

Aspects of Quality	**Mean Scores of Facilities**		
Responses From Check List:	**Ujjain N = 21**	**Sidhi N = 25**	**Total N = 46**
Accessibility Mean	4.76	4.84	4.96
Scale Value	*(0-5)*	*(0-5)*	*(0-5)*
Privacy Mean	5.71	4.76	5.19
Scale Value	*(3-6)*	*(3-6)*	*(3-6)*
Physical Standards Mean	2.86	2.04	2.5
Scale Value	*(0-3)*	*(0-3)*	*(0-3)*
Clinical Standards * Mean	9.14	6.8	8.78
(Drugs) *Scale Value*	*(0-11)*	*(0-11)*	*(0-11)*
Clinical Standards * Mean	14.09	11.56	12.67
(Equipment) *Scale Value*	*(0-17)*	*(0-17)*	*(0-17)*
Responses from Admin, Provider Schedules	**Ujjain N = 31**	**Sidhi N= 31**	**Total N = 62**
Technical Competence Mean	6.48	5.48	5.98
Scale Value	*(1-21)*	*(1-21)*	*(1-21)*
Availability Score Mean	4.12	4.90	4.51
Scale Value	*(0-14)*	*(0-14)*	*(0-14)*

* Note : *The means for the scores of clinical standards of drugs and equipment include the values of 5 facilities which did not permit direct observation but gave oral information.*

Table II: Aspects of Quality of Care Index in Public and Private Facilities

Aspects of Quality Responses From Check List:	Mean Scores of Facilities		
	Public N= 11	Private N= 35	Total N = 46
Accessibility *Mean*	4.81	4.88	4.84
Privacy *Mean*	5.54	5.08	5.31
Physical Standards *Mean*	2.45	2.51	2.48
Clinical Standards (Drugs) *Mean*	8.45	8.88	8.66
Clinical Standards (Equipment) *Mean*	13.63	12.42	13.02
Responses from Admin, Provider Schedules	**Public N = 11**	**Private N= 51**	**Total N = 62**
Technical Competence *Mean*	9.54	5.21	7.37
Availability Score *Mean*	5.63	4.27	4.95

Methodology for Construction of 'Quality of care' index

The quality care of each health facility is measured in terms of its accessibility, privacy, technical competence, physical standard, clinical standard and availability. The computation procedure has mainly seven steps and for the computation we use answers to questions in the checklist and the administrator questionnaire.

Step 1
Computation of Accessibility Scores (P)

The accessibility can be calculated using three variables in checklist schedule. The first variable is the distance from motorable road to the health facility. Question No A1A in checklist questionnaire gives this information. The scores are given accordingly as 5 for ≤ 1 Kilometres, 4 for 2-3 Km, 3 for 4-5 Km, 2 for 6-10 Km and 1 for >10 Km, 0 for "not accessible by road". The score for each category has assigned under the assumption that as the distance increases the client has to spend more money and time and in effect less accessibility. This value can be called **P** (say).

Step2
Computation of Privacy Score (Q)

The three variables in the checklist schedule can be utilised to calculate the privacy score. These variables are B2, B3 and C3 and this measures the auditory and visual privacy. Question No B3 and C3 provide us whether visual privacy is maintained both in the consulting room and recovery room.

We coded 2 for 'Yes' and 1 for 'No' for these three questions and the total privacy is calculated by taking its sum as **Q=B2+B3+C3**.

Step 3
Computation of Technical Competence Score (R)

The technical competence of each Institution is measured in terms of the technical qualification of its doctors. For that we found the highest qualification of each doctor in the facility. Against this qualification for each we give a score and the sum of these scores of all the doctors in an institute. This will give its total score of technical competence available in the facility. We can use question no. C1 in the Administrator questionnaire for this. The score for each qualification are as follows: 0 for degree in Ayurvedic or Homeopathic or Unani or other degree. 1 for MBBS – untrained for MTP, 2 for MBBS – trained for MTP, 3 for DGO and 4 for MS/MD in Obstetrics and Gynaecology.
The score value can be called **R1**.

In addition from the checklist in each institution, check the question numbers E6. If blood bank is available in-house the score is 3, if within a distance of 5 km the score is 2 and if it is greater than 5 km the score is 1. This score is called **R2**.

Using the best provider within the centre check question no. B10A in the provider schedule. If the facility is open at night then give it a score of 2 and if not give it a score of 1. This score is **R3**.
The score on technical competence **R=R1+R2+R3**

Step 4
Computation of Availability Score (S)

This computation of this score is based on some aspects in the provider schedule. The different methods of MTP services provided, during the last three months, af each gestation period forms the main criteria. This speaks the actual availability of services at the institution.

To compute the availability score we utilise the question D4 in the provider questionnaire. The computation procedure can be illustrated with the help of a table. The first step of this is to find out the values of X1, X2, X3, X4, Y1, Y2, Y3 andY4 as given in the table.

Gestation group	*Number of abortions conducted in last three months*	*Major methods used (MVA, D&C, EVA etc)*
Up to 8 weeks	X_1 (give a score '1' if they perform at least one case, other wise put '0')	Y_1 (number of methods used for this gestation group. Put a score '1' if only one method is used)
Up to 12 weeks	X_2 (give a score '2' if they perform at least one case, other wise put '0')	Y_2 (number of methods used for this gestation group. Put a score '1' if only one method is used)
Up to 20 weeks	X_3 (give a score '3' if they perform at least one case, other wise put '0')	Y_3 (number of methods used for this gestation group. Put a score '1' if only one method is used)
Above 20 weeks	X_4 (give a score '0' if they perform at least one case, other wise put '1')	Y_4 (number of methods used for this gestation group. Put a score '1' if only one method is used)

The total service availability score can be computed as

$S=(X_1\times Y_1)+ (X_2\times Y_2)+ (X_3\times Y_3)+(X_4\times Y_4)$

If more than one provider is performing MTP services in an institution, we take the score of one who gets the maximum for the availability score.

For example, if an institution a provider offers MVA and EVA up to 8 weeks and another offers D & C for the period 8-12 weeks, then the score is as given below:

For duration unto 8 weeks the score is 1. Within this duration, there are two options, MVA and EVA available. Therefore the options score is 2.

Then S = 1x (1+1) + 2x (1) = 2 + 2 = 4.

Step 5

Computation of physical standards score

For computing this, use the questions no. Q.D1a, Q.D1b and Q.D1c in the checklist schedule. Give a value of 1 for 'Yes' and 0 for 'No' for the first two questions and also put a value of 1 for 'Good' and 0 for 'Poor' in the last question.

The total score can be called as **T**

Step 6

Computation of Clinical standards score (Drugs)

Drugs: Use question number Q.E4 item number 1 to11 in the checklist questionnaire to find out this. Put a score of 1 for 'Available' and 0 for 'Not available'.

Sum of this score can be taken as **U**.

Step 7

Computation of Clinical Standards score (Equipments)

Equipments: Use question no. Q.EI(1-10) and Q.EII(1-7) in Checklist questionnaire to find out this. Put a score of 1 for 'available' and 0 for 'not available'.

Sum of this score can be taken as V.

Step 8

Calculation of Quality of Care Index

The quality care index is the summation of the total scores obtained in step1 to step 4. That is, it is calculated as:

QCI=P+Q+R+S+T+U+V

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